

THE BEST OF CARE:

GETTING IT RIGHT FOR SENIORS
IN BRITISH COLUMBIA (Part 2)

REPORT | VOLUME 1



Dedication

This report is dedicated to seniors in British Columbia who require care and support and their families and friends. It is also dedicated to the hardworking people who provide care to seniors in British Columbia.

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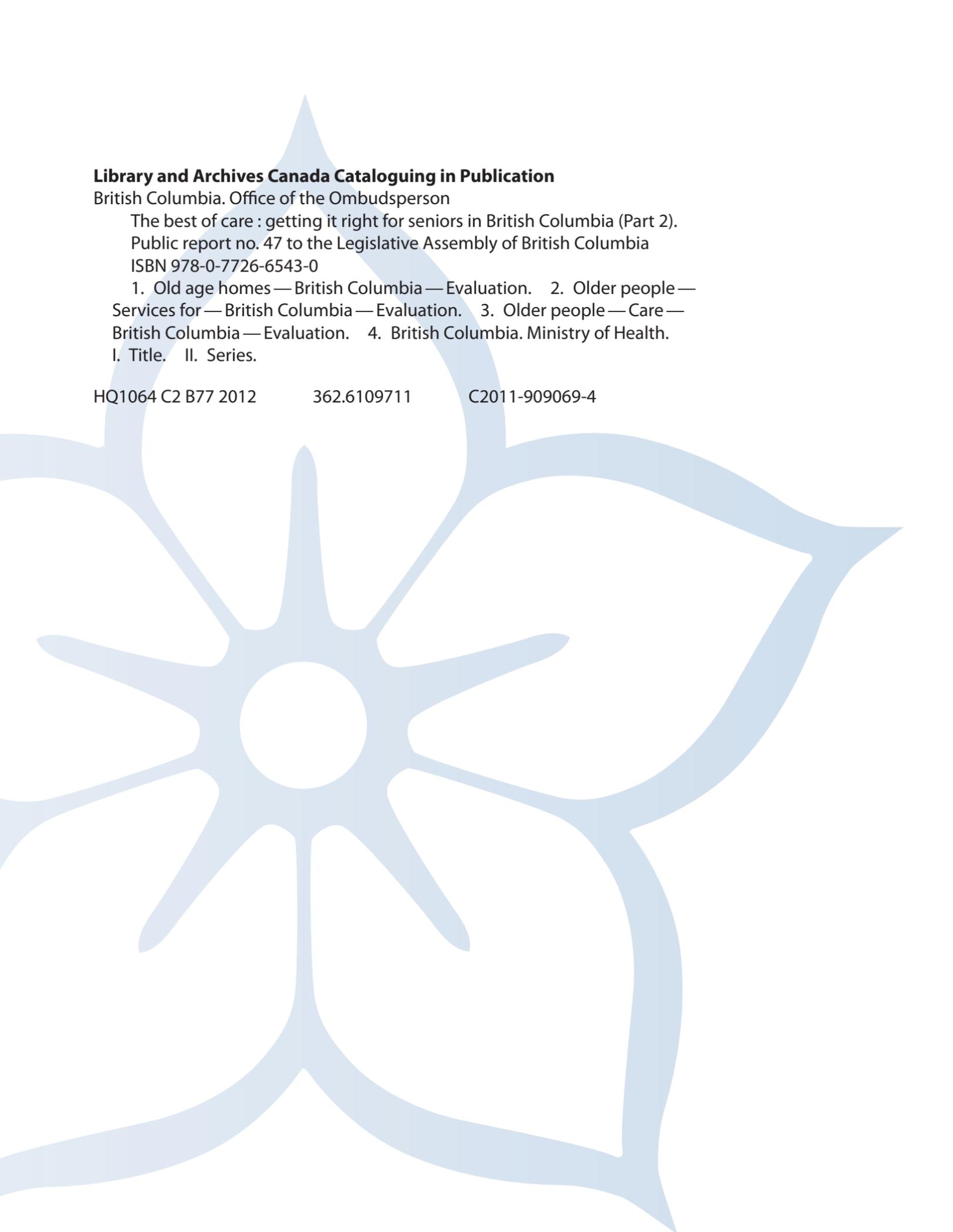
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From the Ombudsperson



Introduction

This report is a comprehensive and in-depth look at home and community care issues affecting seniors in British Columbia from an Ombudsperson's perspective.

As an independent Officer of the Legislature, the Ombudsperson is tasked with oversight of the administrative actions of provincial public authorities with the goal of ensuring they deal with people and deliver services in a fair and reasonable manner. While the Office of the Ombudsperson receives, investigates, and resolves thousands of individual complaints each year, it also has a role to “generally oversee the administrative actions of government authorities with a view to upholding the democratic principles of openness, transparency, and accountability.”

In this investigation, the provincial public authorities we have looked at and that have responsibility for seniors' care are the Ministry of Health and the five regional health authorities: Fraser Health, Interior Health, Northern Health, Vancouver Coastal Health, and Vancouver Island Health. In addition, the Ministry Responsible for Housing was included as it had a role in dealing with the tenancy rights of those seniors in assisted living residences.

Our investigation focusses on issues of administrative fairness including adequacy of information; program accessibility; standards of care; and monitoring and enforcement of those standards.

The complexity of seniors' care issues and the division of responsibility between different provincial public authorities led to a long systemic investigation which has resulted in a two-part public report. Part 1 was released in December 2009 and addressed an important but narrow range of issues in the area of residential care. Part 2 deals not only with residential care but also general home and community care issues; home support; and assisted living – in short, a significant range of interconnected seniors' care services in British Columbia.

As a consequence, Part 2 is a more detailed and diverse report that includes a total of 143 findings and 176 recommendations. The largest number of these recommendations necessarily involve the Ministry of Health taking a leadership role, providing direction and support to health authorities and working in conjunction with them to ensure consistent province wide standards and processes that treat seniors across British Columbia in a fair and equitable manner.

Introduction

Background

This investigation was initiated in 2008 in response to complaints received by the Ombudsperson's Office about various aspects of seniors' care and public concerns about seniors care. It has been one of the longest systemic investigations conducted by this office and has resulted in the most comprehensive report the Office has produced.

While we issued Part 1 of our report in December 2009, Part 2 has taken much longer to complete. Once people have had an opportunity to read it however, I believe they will understand why.

While we express our thanks in other places in the report, I would like to say that the work done by the staff in our office was supported by equally hard-working staff in various parts of the Ministry of Health and the five regional health authorities who are dedicated to improving the system of seniors care in British Columbia and who provided files for review, facts, data, information and ideas to our office and responded to our many questions.

Our approach to issues, as set out in our Act is consultative and resolution-oriented. Our focus is on fixing problems and improving service delivery. We see unfair or unreasonable treatment as ultimately ineffective and inefficient program management.

There are various ways to look at the administrative fairness issues raised in a review of seniors care. We chose to organize our investigation and report under the headings of Home and Community Care, which deals with issues that affect different types of seniors care in British Columbia; Home Support, which deals with issues that affect seniors who receive support services to assist them to continue to live in their own homes; Assisted Living, which deals with issues that affect seniors who live in residences registered as assisted living residences; and Residential Care, which deals with issues that affect seniors who live in residential care facilities.

Equally, each of these major divisions includes sub-headings that deal with administrative fairness issues: availability of information; accessibility of service; standards of care; monitoring and enforcement of those standards; and how complaints about service delivery are dealt with by authorities. So, another way of approaching the report is to look at those issues in a comparative approach across the major home and community care divisions. For example, how standards of care are established and monitored in residential care facilities in comparison to how they are established and monitored in home support.

Finally some people may wish to begin with the recommendations for rectification, change, or improvement, and look at which ones can be done quickly, which ones will take some time to implement, and which are ones where additional study is recommended before a decision is made.

Whichever approach is taken, I think it will be clear that there are many areas where practical improvements can be made that will improve service delivery to seniors and their families and which do not involve complicated and costly changes.

Our Investigative Process

In conducting this systemic investigation we obtained information from a number of different sources. Foremost was from the Ministry of Health and the five regional health authorities. In situations where there were any differences that could not be reconciled in the information or data we received from the Ministry

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and the health authority, we have relied upon the health authority data as it has been collected closest to the source. In addition, we obtained information during the course of our investigations into individual complaints. We also received information from various stakeholder groups and from individuals who had experiences as “end users” with the seniors care system in British Columbia. All this information was supplemented with visits that we made to assisted living and residential care facilities and to home support agencies.

At a relatively early stage in our investigation, we identified three interrelated areas where we believed straightforward changes could be made that would quickly improve the quality of life for seniors in residential care facilities. The changes we recommended were clearly setting out the rights of seniors living in all types of residential care facilities and ensuring these rights were respected; providing timely access to useful, consistent and comparable information on residential care facilities; and providing support for the role of resident and family councils. The recommendation on establishing a Residents’ Bill of Rights was accepted and implemented in November 2009.

The themes that were highlighted in Part 1 of the report include the importance of ensuring equal rights and consistent standards of care and protection; timely access to useful, and accurate information; and the importance of considering the input and interests of seniors and their families in the delivery of services. These themes continue to be reflected throughout this part of the report.

Once our investigation was complete, we followed our normal process of providing a draft report to the authorities to provide them with an opportunity to respond. A copy of the draft report including our preliminary findings and recommendations was sent to the Ministry of Health and the health authorities on October 28, 2011. We provided an opportunity for them to identify any factual clarifications they believed should be included and which they believed would be useful in finalizing our findings and recommendations.

Format of This Report

One of the questions that I expect to be asked is “why is Part 2 of this report so long and detailed” and “why are you making so many specific recommendations”. In answering the first question, I can also answer the second.

Home and community care in British Columbia is a complex and interconnected system involving a number of provincial government authorities as well as private service providers (both for profit and not for profit). In order to ensure that our recommendations are useful and practical, it was necessary to look at a range of services rather than to deal with them on a piecemeal basis.

I also believed a detailed report would, in addition to explaining the rationale for recommending certain changes and improvements, illustrate what sort of information could be usefully provided to the public.

We have also produced a summary of the report which is found in the volume titled “Overview”. This contains the essential information underlying the recommendations but it does not contain all the detailed supporting information. I would stress that the full report, or the section that deals with the issue you are interested in, should be read to fully understand and appreciate the reasons for the recommendations. The summarized version has also been produced in a larger font to increase accessibility.

Introduction

Progress to Date

I believe that there has already been some improvements made during the course of our investigation. Clearly, the recognition of the importance of ensuring consistent standards of protection for all seniors receiving similar care that the Bill of Rights embodies is significant.

One of the advantages of a longer investigation is that it can provide an opportunity for changes and improvements to be made by authorities while responding to our inquiries. That has happened during this investigation.

An example of this is that the Ministry of Health changed its policy in April 2011 to eliminate a long-standing distinction between the rates charged to some sponsored immigrants for residential care and those charged to other seniors. In the same April 2011 manual there is a new chapter on performance management in home and community care services that stresses the importance of performance standards, performance measures, reporting progress and quality improvement. Those are themes that are echoed in specific recommendations in this report.

In addition the Ministry of Health completed and publicly released a report on the use of antipsychotic drugs in British Columbia Residential Care Facilities in December 2011.

Equally, I have observed movement over the past three years towards the Ministry of Health taking a more active stewardship role in the area of seniors' care. I believe the Ministry and health authorities responses to this report reflect a recognition that the Ministry, with its policy making and funding responsibilities, is the only agency that has both the ability and authority to ensure that issues of accessibility, standards of care, and monitoring and enforcement of these standards are consistently addressed.

Looking back at Part 1 of this report, which was issued in December 2009, I am also heartened that many groups have "taken up the cause" of some of the recommendations that were not implemented at that time, such as the establishment of a single provincial website reporting useful information about residential care facilities, and are still pushing for their full implementation. There have been improvements in the amount of information made available to seniors and their families about seniors' care and it is also noteworthy that the Ministry of Health, in its response to this report, identified that one of its immediate priorities was taking action to improve the accessibility of information.

Areas Dealt With in this Report

In a comprehensive and detailed report it is often easy to get lost trying to identify what are the most significant recommendations. In this case, I believe, given the range and number of recommendations, it is most useful to look at some underlying themes that connect the recommendations.

At the highest level, those themes are support; protection; consistency; and choice. Almost every recommendation relates to one of those themes. For example, our recommendations about information and reporting are designed to improve consistency and to facilitate choice. Our recommendations about accessibility are designed to improve support, protection, and choice. Our recommendations about standards, monitoring, and enforcement are designed to improve protection and consistency.

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Key issues include providing adequate, accurate and accessible information to seniors and their families to allow them to make necessary decisions in an informed manner; evaluating the consistency of current home support criteria with the government's provincial goals and principles and the overall goals of the home support program; expanding current programs such as standard training, supervision of gift giving and criminal records checks to ensure equal protection for all vulnerable seniors receiving home support, assisted living and residential care; ensuring that vulnerable seniors have equal or better protection than other British Columbians in areas such as tenancy; creating one statutory and regulatory framework for all residential care facilities in BC; and establishing clear, objective measurable and enforceable standards of care in home support, assisted living and residential care.

Areas where improvements can be made can also be grouped under administrative fairness issues. It is important that seniors have timely access to useful information which is why, for example, I have recommended that the Ministry of Health work with health authorities to develop a program to ensure all seniors and their families are informed of the availability of home and community care services (Recommendation 9) and ensure information about application processes and how to apply for fee waivers are clear, consistent, and available to all those who may benefit from them (Recommendations 11 and 41).

It is important that the Ministry of Health and health authorities have clear authority for the actions they take which is why, for example, I have recommended that the Ministry of Health ensure there is a clear, province-wide policy on when the *Mental Health Act* can be used to involuntarily admit seniors to mental health facilities and then transfer them to residential care facilities (Recommendation 130) and that the health authorities stop charging fees to these seniors who are involuntarily detained in residential care facilities (Recommendation 131).

It is important that seniors in similar circumstances receive similar care and protection and support which is why, for example, I have recommended that the Ministry of Health takes steps to end the two different legislative frameworks that apply to residential care, the *Community Care and Assisted Living Act* and the *Hospital Act* (Recommendation 94), which result in unfair differences in services, standards, monitoring, and fees. As well, I have recommended that the Ministry of Health take the necessary steps to require operators of residential care facilities governed under the *Hospital Act* to report incidents in the same manner as facilities licensed under the *Community Care and Assisted Living Act* (Recommendation 162).

It is important that standards of care are clear and enforceable which is why, for example, I have recommended that the Ministry of Health, after consulting, establish specific and objectively measurable regulatory standards that apply to key aspects of care in all residential care facilities (Recommendation 133) and similarly, it establish standards of care for key areas in assisted living residences (Recommendation 69) and home support services (Recommendation 42).

It is important that the organization responsible for monitoring and enforcing standards have the tools they need to do so effectively which is why, for example, I have recommended that the Assisted Living Registrar be given expanded authority to obtain information about incidents it is tasked with investigating and the Ministry of Health develop an active inspection and monitoring program for assisted living residences (Recommendations 90 and 88), as well as expanding the enforcement options that apply to residential care facilities under the *Community Care and Assisted Living Act* (Recommendation 166).

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It is important that seniors receiving care and their families have access to timely and responsive complaint systems, which is why, for example, I have recommended that the Ministry of Health revise and expand the complaints process of the Assisted Living Registrar (Recommendations 75, 78 and 79) and require all residential care facility operators to have a process for responding to complaints (Recommendation 148).

It is also important that authorities track and have access to the information needed to ensure they can fulfill their oversight roles which is why, for example, I have recommended that the Director of Licensing in the Ministry of Health receive quarterly reports about the number and nature of residential care complaints and reportable incidents from the regional health authorities (Recommendation 151) and that the Ministry of Health, when developing new information management systems, ensure the new system is fully operational before allowing information reported under the old system to be discontinued (Recommendation 6).

While I believe it is the inter-connectedness of the recommendations which is the real strength of this report, I am sure that one or another of them may resonate with individual readers as most important because of their particular circumstances.

Responses of Authorities

I believe it is clear from the Ministry of Health's response it believes there is significant public interest in seniors care and it has indicated that this report's focus on issues such as accessibility, consistency, continuity, accountability, transparency, and choice are ones that it supports. It has indicated its immediate priorities will be to improve administrative fairness and access to information within the current legislative and regulatory framework and it recognizes the need for timely responses to concerns and complaints, as well as for greater navigational support for system users.

As the Ministry of Health has also taken the lead in responding to recommendations directed to all the health authorities, this means that the great majority of the recommendations in the report are in its hands.

The responses of the individual health authorities have focussed on the specific recommendations directed to them. The majority have been accepted and are being implemented. In situations where a health authority has not accepted a finding or recommendation I have carefully considered the rationale it provided for not doing so.

I recommended that Interior Health track the length of time seniors wait to be assessed for home and community care services (Finding 7 and Recommendation 8). This was based on its inability to provide factual information on tracking for the entire health authority. The information provided did not include the Kootenay Boundary area. Consequently I have not changed this finding. I also recommended Interior Health fully comply with a February 2009 directive issued by the former Ministry of Health Services by including a description of the complaints processes and direct contact information for the Patient Care Quality Review Board and the Office of the Assisted Living Registrar on its website (Finding 57 and Recommendation 71). This was based on reviews of Interior Health's website done in June and December 2011. The website did not include a description of the complaints processes and direct contact information for the Patient Care Quality Review Board and the Office of the Assisted Living Registrar. Consequently I have not changed this finding.

I also recommended that Vancouver Coastal track the length of time seniors wait to be assessed for home and community care services (Finding 7 and Recommendation 8). Vancouver Coastal recently began recording what percentage of the time it met performance measures for seeing a home and community care

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client after a referral within timeframes ranging from 24 hours to two weeks. While that may be very useful information, it is not the same as tracking the actual time that a senior waits for a home and community care assessment. Vancouver Coastal Health has confirmed that currently it does not have information available on average wait times for assessment or the number of seniors waiting for an assessment. Consequently I have not changed this finding. Vancouver Coastal's response concerning Finding 57 and Recommendation 71 is an example of where, when an authority provides additional or updated information that establishes that a finding and recommendation no longer applies to them, then I reflect that in the appropriate finding and recommendation.

The response from the Minister Responsible for Housing clarifies that it is now the Ministry of Health which is now responsible for issues relating to assisted living tenancies.

Conclusion

Administrative fairness operates within a wider context. During the course of our investigation into home and community care issues, it became evident that context includes questions about whether the changes in service delivery models for seniors care made since 1984 should be considered during any review of the *Canada Health Act*; whether a conversation with seniors and others about the type of services needed, their costs and how these costs are paid, would be timely and produce positive change; whether there is a rationale for the difference in support in British Columbia provides to vulnerable children and their families (a Ministry and a provincial-level representative) and vulnerable seniors and their families; and whether the current home and community service delivery model which is a mix of private and public agencies delivering home and community care services under contract to the health authorities is the most effective model. While, to the disappointment of some, I have made it clear those issues are not matters which fell within the scope of this investigation, I hope that this report will still be valuable to those who are engaged in considering such matters.

I will conclude by saying, as I have done in earlier reports, that this is a lengthy and detailed examination of a complex and important government program. I believe that it has demonstrated areas where fair and reasonable policies, processes, and procedures will improve program delivery and as a result, the lives of individual British Columbians. The focus on good administration, service delivery, and accountability approached through the Ombudsperson lens of fairness and reasonableness will, I believe, assist the Ministries and health authorities and their staff who provide these important services as well as the seniors who receive them – who may from time to time be us, or our family members, friends and colleagues.



Kim S. Carter
Ombudsperson
Province of British Columbia



Background

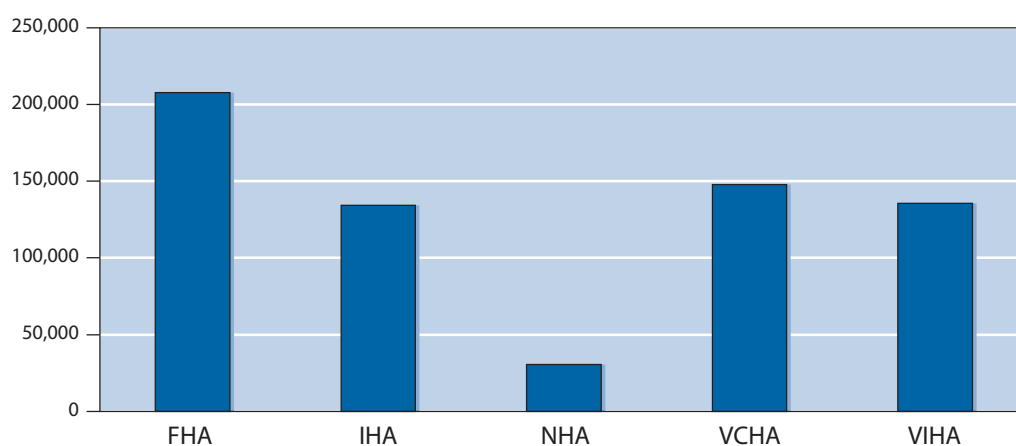
In British Columbia, the five regional health authorities deliver provincial programs and services to seniors, under the direction and oversight of the Ministry of Health.¹ The ministry sets the strategic direction for service delivery by legislating, regulating, creating policy, providing funding and setting specific expectations.

This section begins with an overview of the senior demographic in British Columbia, and goes on to discuss the values and philosophy that provide the foundation for the delivery of care and services to seniors in the province. It also describes the range of home and community care services provided to seniors, the legislative and regulatory framework that guides their delivery, and the roles and responsibilities of those involved in their planning, delivery and oversight.

Who Are British Columbia's Seniors?

In this report, we define seniors as people who are 65 years or older. BC Stats has estimated that 677,770 seniors were living in B.C. in 2010.² As shown in Figure 1, the distribution of seniors varies considerably across the province. The Fraser Health Authority (FHA) serves more seniors than any other health authority; as it is home to almost one-third of the provincial population of seniors. The Northern Health Authority (NHA) has the fewest seniors. The Interior Health Authority (IHA), Vancouver Coastal Health Authority (VCHA) and Vancouver Island Health Authority (VIHA) provide services to a similar number of seniors.

Figure 1 – Population of Seniors by Health Authority, 2009



¹ There are six health authorities in British Columbia. The five regional health authorities are Fraser Health Authority, Interior Health Authority, Northern Health Authority, Vancouver Coastal Health Authority and Vancouver Island Health Authority. There is also the Provincial Health Services Authority, which is not a regional body, but instead coordinates specialized health care services and operates agencies such as the BC Cancer Agency, the BC Centre for Disease Control, BC Children's Hospital and BC Transplant. While the Provincial Health Services Authority also provides services to seniors, this report focuses on the role of the five regional health authorities in providing home and community care services. For the purpose of this report, we will refer to the regional health authorities collectively as the health authorities.

² BC Stats, *British Columbia Population Projections 2011 to 2036*, September 2011, 35.

Background

Seniors make up approximately 15 per cent of British Columbia's total population, up from 13 per cent in 1998, and slightly higher than the national average of 14 per cent.³ As British Columbia's overall population continues to age, the proportion of those who are 65 or older will grow. By 2020, seniors are expected to make up 19 per cent of the provincial population of British Columbia, increasing to 24 per cent by 2036.⁴ In other words, today's provincial senior population of approximately 678,000 will grow to an estimated 984,000 in 2020, and will reach nearly 1.46 million in 2036, 25 years from now.

From 2001 to 2008, the number of people aged 65 and over in British Columbia grew by 18 per cent. However, a closer look at the numbers reveals that while both the group of seniors aged 65 to 74 and those aged 75 to 84 grew by 15 per cent, the group composed of seniors aged 85 and older grew by 43 per cent in this period. It is now estimated that more than 90,000 residents of British Columbia are 85 or older. Considering that seniors over the age of 75 generally require more health care services and support than younger seniors, this demographic trend highlights the importance of ensuring that adequate services are in place.

As the provincial population ages, the needs of older British Columbians are also changing. Seniors are now more likely to work later in life than they were in the past. According to Statistics Canada, approximately 40 per cent of men and 20 per cent of women continue to work past the age of 65.⁵ More than 10 per cent of all seniors continue to work past the age of 75.⁶

In 2006, (the most recent year for which statistics are available) approximately 5 per cent of British Columbian seniors lived in a health care facility, such as a hospital, nursing home or other care institution. For seniors over 75, the number was 10 per cent.⁷ A significant proportion of British Columbian seniors also lived alone. In the 2006 census, 36 per cent of women and 17 per cent of men aged 65 and over reported living alone.⁸ Seniors who are 85 or older are even more likely to live alone. Fifty-nine per cent of women and 31 per cent of men in this age group lived alone in 2006.⁹

Many seniors rely on family, friends and volunteer caregivers for emotional support and help with their daily activities, but this type of support may not be available to all seniors, and some seniors may need services beyond what friends and family can provide. Home and community care services can fill these gaps. Accordingly, as British Columbia's population ages and the proportion of seniors increases, our health care system will need to be positioned to meet their care needs.

Demographics

Seniors make up 15 per cent of B.C.'s population. While the overall number of seniors is growing at a slightly faster rate than the population as a whole, the group of seniors aged 85 and older is growing more than three times faster than the rest of the senior population.

³ BC Stats, *2006 Census Fast Facts: Living Arrangement for B.C. Seniors*, 2006, 1.

⁴ BC Stats, *British Columbia Population Projections 2011 to 2036*, September 2011, 5.

⁵ Statistics Canada, *A Portrait of Seniors in Canada*, 2006, 131.

⁶ Statistics Canada, *A Portrait of Seniors in Canada*, 2006, 130.

⁷ BC Stats, *2006 Census Fast Facts: Living Arrangement for B.C. Seniors*, 2006, 5.

⁸ BC Stats, *2006 Census Fast Facts: Living Arrangement for B.C. Seniors*, 2006, 4.

⁹ BC Stats, *2006 Census Fast Facts: Living Arrangement for B.C. Seniors*, 2006, 4.

Background

Values and Principles for Care

Programs for seniors in British Columbia should be consistent with and promote the core values and principles recognized at the international, national and provincial levels. The values and principles outlined in this section have also guided the Ombudsperson's investigation into seniors' care and inform this report.

The Ombudsperson's Standard of Fairness

The Ombudsperson is an independent officer of the Legislature appointed pursuant to the *Ombudsperson Act*. She has the responsibility to advise government on systemic causes of unfairness and to recommend changes to practices, policies and legislation that contribute to recurring unfairness. Recommendations made by our office are informed by the Ombudsperson's statutory mandate, as well as by the principles of natural justice and administrative fairness.¹⁰ The Ombudsperson seeks to uphold the democratic principles of openness, transparency and accountability, and to ensure that every person in British Columbia is treated fairly in the provision of public services.

International

The United Nations General Assembly adopted the United Nations Principles for Older Persons in 1991. While these principles do not bind member states, governments are encouraged to include them in their programs. The principles set out specific goals for seniors under the headings of independence, participation, care, self-fulfillment and dignity. Canada has committed to upholding the spirit and intent of the principles by integrating the rights and needs of older persons into economic and social development policies.¹¹

In March 2010, Canada ratified the United Nations Convention on the Rights of Persons with Disabilities. Some principles of the convention that may apply to seniors with physical and cognitive limitations include respect for inherent dignity, individual autonomy, independence of persons, non-discrimination, full and effective participation and inclusion in society, accessibility, equality, respect for differences and acceptance of persons with disabilities as part of human diversity and humanity.¹² In ratifying the convention, Canada has recognized the rights of seniors with disabilities.

Canada

In 1999, the federal government, the provinces and the territories worked together to develop a coordinated plan for addressing seniors issues, known as the Canadian National Framework on Aging.¹³ The framework was developed to enable effective analysis of seniors programs and services across the country. The United Nations Principles for Older Persons informs the framework's vision statement, which affirms that "Canada, a society for all ages, promotes the well-being and contributions of older people in all aspects of life." The five principles at the core of the framework are dignity, independence, participation, fairness and security.

¹⁰ An administrative fairness checklist can be found in the Ombudsman's 1990 Annual Report to the Legislative Assembly.

¹¹ Government of Canada, *Addressing the Challenges and Opportunities of Aging in Canada*, 2007, 1-3.

¹² United Nations, Convention on the Rights of Persons with Disabilities, 13 December 2006, Article 3.

¹³ The framework was an initiative of the federal, provincial and territorial ministers responsible for seniors, with the exception of Quebec.

Background

British Columbia

A commitment to “build the best system of support in Canada for persons with disabilities, those with special needs, children at risk and seniors” was identified in the province’s *2011/12-2013/14 Strategic Plan* as one of five “great goals for a golden decade.” The plan also identifies the following core values of B.C.’s government:

- *integrity*: to make decisions in a manner that is consistent, professional, fair, transparent and balanced
- *fiscal responsibility*: to implement affordable public policies
- *accountability*: to enhance efficiency, effectiveness and the credibility of government
- *respect*: to treat all citizens equitably, compassionately and respectfully
- *choice*: to afford citizens the opportunity to exercise self-determination

The *2011/2012-2013/14 Strategic Plan* identifies as a performance measure ensuring that British Columbia has the second lowest level of seniors 75 or older living in health care or related institutions. In September 2008, the provincial government released *Seniors in British Columbia: A Healthy Living Framework*. The stated goal of the framework is to make British Columbia “the best place on earth for older people” by “building the best system of support in Canada for our older citizens.”¹⁴

The framework has four cornerstones:

- create age-friendly communities
- mobilize and support volunteerism
- promote healthy living
- support older workers

Seniors’ Healthy Living Framework

The provincial government declared in 2008 that the goal of the framework was to make B.C. “the best place on earth for older people” by “building the best system of support in Canada for our older citizens.”

Source: *Seniors in British Columbia: A Healthy Living Framework*, 2008.

The Seniors’ Healthy Living Secretariat, which is part of the Ministry of Health, is responsible for leading the implementation of the framework.

The Ministry of Health is the overall steward and funding agency of the provincial health care system. The following principles appear on the ministry’s website:

- clients and their families should have the information required to make their own decisions about lifestyle and care
- clients have the right to make their own care decisions
- home and community care services will promote the well-being, dignity and independence of clients
- palliative care services will provide the best possible quality of life for people nearing the end of their life and their families¹⁵

¹⁴ Ministry of Healthy Living and Sport, *Seniors in British Columbia: A Healthy Living Framework*, 2008, 3.

¹⁵ Ministry of Health, “Home and Community Care” <<http://www.health.gov.bc.ca/hcc/index.html>>.

Background

Roles and Responsibilities

This section describes the roles and responsibilities of the key agencies involved in providing care to seniors in British Columbia. At the provincial level, responsibility for seniors' care was formerly divided between the Ministry of Health Services and the Ministry of Healthy Living and Sport. The latter ministry was eliminated in October 2010, leaving the full responsibility for seniors' care with the Ministry of Health Services, which was renamed the Ministry of Health in March 2011.

Ministry of Health

The Ministry of Health sets the overall strategic direction for the provincial health system and oversees its operation. It is responsible for establishing policy, setting priorities, allocating funding and developing performance indicators. It is also responsible for measuring performance against those indicators. The ministry describes its stewardship role in its *2011/12-2013/14 Service Plan* as:

The Ministry of Health (the Ministry) has overall responsibility for ensuring that quality, appropriate, cost effective and timely health services are available to all British Columbians. The Ministry works with health authorities, care providers, agencies and other groups to guide and enhance the Province's health services and ensure British Columbians are supported in their efforts to maintain and improve their health and to provide access to care. The Ministry provides leadership, direction and support to these service delivery partners and sets province-wide goals, standards, and expectations for health service delivery by health authorities. The Ministry enacts this leadership role through the development of social policy, legislation and professional regulation, through funding decisions, negotiations and bargaining, and through its accountability framework for health authorities and oversight of health professional regulatory bodies.

The Province's six health authorities are the organizations primarily responsible for health service delivery. The delivery of health services and the health of the population are monitored by the Ministry on an ongoing basis. These activities inform the Ministry's strategic planning and policy direction to ensure the delivery of health information and services continue to meet the needs of British Columbians.

Stewardship

According to the World Health Organization (WHO), "stewardship in health is the very essence of good government," and ministries of health are the stewards of their health care systems. The WHO considers good stewardship to consist of three overarching responsibilities:

- *providing vision and strategic direction for the health system*
- *collecting and applying information to guide improvements in performance*
- *regulating and governing the operation of health systems*

Source: WHO, World Health Report 2000 — Health Systems: Improving Performance, 117.

Provincial Home, Community and Integrated Care Executive Leadership Team

The provincial Home, Community and Integrated Care Executive Leadership Team acts as a link between the Ministry of Health and the regional health authorities. The council provides information and advice on the development, implementation and evaluation of home and community care planning, policy, legislation,

Background

standards and programs. The council includes representatives from each of the health authorities, and has standing committees on residential care, end-of-life care, assisted living, and the Home Health Services Working Group for home support and home nursing.

Home, Community and Integrated Care Branch

The Home, Community and Integrated Care Branch of the Health Authorities Division, Ministry of Health, is responsible for the development and implementation of legislation, policy and guidelines to protect the health and safety of people receiving care in licensed residential care facilities.

The director of licensing, an employee of the Ministry of Health, is the steward for the provincial community care licensing program, is responsible for setting policies and practice standards for community care facilities and has specific powers under section 4 of the *Community Care and Assisted Living Act* (CCALA). The director of licensing has the power to:

- inspect or order an inspection of a facility
- require a health authority to audit a community care facility
- investigate or order the investigation of a reportable incident or a health and safety matter
- require a health authority to provide routine or special reports on the operation of licensed community care facilities
- make other orders the director considers necessary for the operation of a community care facility or for the health and safety of persons in care, including an order that is contrary to the decision of a medical health officer

The director's authority does not extend, however, to facilities that are governed by the *Hospital Act*, although these facilities offer the same services as those licensed under the CCALA. (Further information about the role of a medical health officer can be found under "Health Authorities" in this section of the report.)

Provincial Health Officer

The provincial health officer is the most senior public health official in British Columbia. The person in this position provides independent advice on the health of British Columbians to the Minister of Health. Each year, the provincial health officer publishes a report on the health of the population, which may include recommendations, and the Minister of Health must table the report in the Legislature. The provincial health officer is also required to report to the public on the health of the population and other health issues.¹⁶ Under section 67 of the *Public Health Act*, the provincial health officer is authorized, in specified circumstances, to exercise any powers or perform any duties of a medical health officer.

Office of the Assisted Living Registrar

The assisted living registrar is designated by the Minister of Health under the *Community Care and Assisted Living Act*. The mandate of the Office of the Assisted Living Registrar (OALR), which is an integral part of the Ministry of Health, is to protect the health and safety of residents in assisted living residences. The Act requires assisted living facilities to be registered with the OALR.

¹⁶ Ministry of Health, "Office of the Provincial Health Officer" <<http://www.health.gov.bc.ca/pho/index.html>>.

Background

The registrar can establish health and safety standards, policies and procedures that apply to assisted living settings. He or she is responsible for ensuring that these standards are followed and is authorized to enforce compliance.

The registrar is also responsible for receiving and acting on complaints about assisted living residences or services. The registrar has authority over all assisted living facilities, regardless of how they are owned or operated and whether or not they are publicly subsidized.

Community Care and Assisted Living Appeal Board

The Community Care and Assisted Living Appeal Board is a tribunal established under the *Community Care and Assisted Living Act*. The board is authorized to hear appeals of various actions and decisions taken by medical health officers and their delegates and by the assisted living registrar, including:

- the appointment of an administrator to operate a community care facility
- a refusal to issue a licence to operate a community care facility
- a refusal to register an assisted living residence
- a decision that a medical health officer or delegate makes about the licence of a community care facility or that the assisted living registrar makes about the registration of an assisted living residence
- a decision to grant an exemption to a requirement of the *CCALA* or regulation

The board can confirm, reverse or vary a decision under appeal. It may also send the matter back for reconsideration, with or without directions, to the person who made the initial decision. A person can apply to the board to suspend the operation of the decision under appeal pending the outcome of the appeal. Appeals to the board allow for the presentation of new evidence or arguments, and the applicant bears the burden of showing why the decision under appeal was not justified.

Seniors' Healthy Living Secretariat

The Seniors' Healthy Living Secretariat in the Ministry of Health, which has a staff of 16, was established in 2008 and is responsible for implementing the Healthy Living Framework for seniors across government.

Health Authorities

In 1993, the provincial government passed legislation to begin the transfer of responsibility for the delivery of health services to health authorities, which were originally called “regional health boards” and “community health councils.”¹⁷ The structure and number of health authorities have changed considerably since then. For instance, there are no longer any community health councils. There are now five health authorities that deliver health services within their respective regions:

- the Fraser Health Authority (FHA)
- the Interior Health Authority (IHA)
- the Northern Health Authority (NHA)

¹⁷ *Health Authorities Act*, R.S.B.C. 1996, c. 180, Part 2.

Background

- the Vancouver Coastal Health Authority (VCHA)
- the Vancouver Island Health Authority (VIHA)

A sixth health authority, the Provincial Health Services Authority (PHSA), is responsible for managing the quality, coordination and accessibility of selected province-wide health programs and services. These include specialized programs and services that are provided through a number of agencies, including the BC Cancer Agency, the BC Centre for Disease Control, the BC Women's Hospital and Health Centre, and the BC Transplant Society. Unless stated otherwise, any references to health authorities in this report do not include the PHSA.

Figure 2 – British Columbia Health Regions, 2002 to Present



The overall mandate of each health authority is to plan, deliver, monitor and report on health services within its region. These services include acute care, home and community care, public and population health programs, care for people with mental health or substance abuse problems and environmental health services.¹⁸

¹⁸ Minister of Health Services, Government Letter of Expectations to the health authorities, April 1, 2009-March 31, 2010, 1.

Background

With respect to home and community care, key responsibilities within each health authority are to provide a range of professional and non-professional care in the community appropriate to meet the needs of seniors, including support for acute care needs (following discharge from hospital, or to avoid hospitalization), management of chronic conditions and disabilities, and end-of-life care. In addition, health authorities are responsible for the assessment, placement and ongoing case management of individual seniors. Health authority staff are also employed to provide home support services directly or to oversee contracts with private service providers. Similarly, residential care facilities may be owned and operated by health authorities or by private operators, both for-profit and non-profit, which contract with health authorities to provide these services. Other health authority responsibilities include managing facility licensing and inspections, processing complaints and maintaining patient care quality offices and review boards.

Medical Health Officers

Medical health officers (MHOs) are appointed by order-in-council under the *Public Health Act* to act within specific health authorities. All medical health officers are physicians who specialize in the area of public health.

There is typically a chief medical health officer within a health authority to whom the other MHOs report. The chief MHO ordinarily reports to the CEO or another executive member of the health authority regarding program responsibilities. The job descriptions for MHOs indicate they are also responsible to the provincial health officer, for the quality of their work.

Medical health officers fulfill a number of statutory functions referred to in various acts and regulations. For instance, the *Community Care and Assisted Living Act* gives MHOs the authority to issue licences to operate community care facilities, inspect premises that are operating as community care facilities, investigate complaints about unlicensed community care facilities and to revoke, suspend, cancel or attach terms and conditions to facility licences.¹⁹ In practice, medical health officers often delegate many of these powers to licensing officers, who are employees of the health authorities.

Patient Care Quality Offices and Patient Care Quality Review Boards

When the *Patient Care Quality Review Board Act* was passed in 2008, every health authority was required to establish a patient care quality office (PCQO).²⁰ All the health authorities have now done this. The purpose of a PCQO is to receive and address complaints from patients about the quality of health care they have received. The PCQOs in each health authority must report the outcomes of their complaint investigations to the relevant complainants, and let them know they have a right to a further review by their local patient care quality review board if they remain dissatisfied.

A patient care quality review board (PCQRB) has been established under the *Patient Care Quality Review Board Act* for each authority, including the Provincial Health Services Authority, and their members are appointed by the Minister of Health. These boards review and resolve complaints that have been submitted

¹⁹ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, ss. 9, 11, 13 and 15.

²⁰ *Patient Care Quality Review Board Act*, S.B.C. 2008, c. 35, s. 2.

Background

following processing of a complaint by a PCQO. In addition to the annual report that the boards are required to submit to the minister, each PCQRB can also submit recommendations for improving patient care to the minister or to the health authority. The first boards were appointed in October 2008.

Legislative Framework

Federal Legislation

Under Canada's division of powers between the federal and provincial governments, health care and the delivery of health services are primarily the responsibility of the provinces and territories. However, the federal government exerts significant influence on health care delivery through its funding contributions. The *Canada Health Act* establishes the criteria and conditions the provinces and territories must meet to be eligible for 100 per cent of available federal government health care funding.

The purpose of the *Canada Health Act* is “to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.”²¹ The phrase “insured health services” is defined in section 2 of the Act as hospital, physician and surgical-dental services provided to those who are insured.²² Home and community care services do not qualify.

“Extended health care services” include intermediate care provided in a nursing home, adult residential care, home care and ambulatory health care services (for those who are able to visit a care centre). Although the Act states that it establishes criteria and conditions respecting extended health care services, these services are in fact excluded from the funding criteria and national standards contained in the Act.

Provincial Legislation

Community Care and Assisted Living Act

The *Community Care and Assisted Living Act* (CCALA) and its related *Residential Care Regulation* govern approximately 70 per cent residential care facilities and

The Canada Health Act

Since the Canada Health Act came into effect in 1984, health care policy has shifted in focus from hospital-based care toward home-based care. Home and community care services are not covered by the Act because they are not delivered in hospitals or by physicians.

As the trend toward more home-based care continues, the effect of the exclusion of home and community care services from the Act is becoming more significant. The Canada Health Act's strength and importance is being reduced as a growing number of medically necessary services are delivered outside the acute care system and are thus no longer subject to the terms of the Act.

²¹ *Canada Health Act*, R.S.C. 1985, c. C-6, s. 4.

²² *Canada Health Act*, R.S.C. 1985, c. C-6, s. 2.

Background

all assisted living facilities in the province. Together, they set the mandatory minimum standards for health and safety, building requirements, staffing, food service, the administration of medication and other matters in those facilities.

Under the *CCALA*, residential care facilities and assisted living residences are authorized to provide prescribed services. Prescribed services are defined in section 2 of the *Community Care and Assisted Living Regulation* as:

- regular assistance with activities of daily living, including eating, mobility, dressing, grooming, bathing or personal hygiene
- central storage of medication, distribution of medication, administering medication or monitoring the taking of medication
- maintenance or management of the cash resources or other property of a resident or person in care
- monitoring of food intake or of adherence to therapeutic diets
- structured behaviour management and intervention
- psychosocial rehabilitative therapy or intensive physical rehabilitative therapy

The number of prescribed services provided is the key legal distinction between a residential care facility and an assisted living residence. If an operator provides three or more prescribed services at a facility, it must be licensed as a “community care facility.” When an operator provides only one or two prescribed services in a particular facility, it can be registered as an assisted living residence.²³

The Regulatory History of Community Care Facilities in British Columbia

While community care facilities today provide a broad range of care services, including residential care and day care for adults in British Columbia, these types of facilities were first licensed as “welfare institutions” because they originally emphasized assistance for the poor and the indigent.

Although earlier legislation can be traced back to the 1940s, the first law specifically devoted to the regulation of community care facilities in British Columbia was passed in 1969 and administered by the Ministry of Social Welfare. The Community Care Facilities Licensing Act and its related regulations established many of the basic principles that are still recognizable in today’s legislation.

There were numerous amendments to the Act between 1969 and 2002, including one in 1979 that renamed it the Community Care Facility Act. In 2002, the Act was significantly revised and the new Act was called the Community Care and Assisted Living Act. Although most of the current version of the Act became effective on May 14, 2004, some sections remain unproclaimed.

²³ The provision of prescribed services is not relevant to the licensing of private hospitals or extended care hospitals providing residential care services under the *Hospital Act*.

Background

A residential care facility licensed under the *CCALA* is one type of community care facility defined in section 1 of the Act as:

- a premises or part of a premises
- a) in which a person provides care to 3 or more persons who are not related by blood or marriage to the person and includes any other premises or part of a premises that, in the opinion of the medical health officer, is used in conjunction with the community care facility for the purpose of providing care, or
- b) designated by the Lieutenant Governor in Council to be a community care facility.

“Care” is defined in section 1 of the Act as:

- supervision that is provided to ...
- c) an adult who is
 - i) vulnerable because of family circumstances, age, disability, illness or frailty, and
 - ii) dependent on caregivers for continuing assistance or direction in the form of 3 or more prescribed services.²⁴

The *CCALA* states that operators of facilities licensed under the *CCALA* must comply with the Act and its regulations and operate their facilities in a way that does not jeopardize the health and safety of residents.

The director of licensing in the Ministry of Health and medical health officers monitor and enforce standards for the care provided in residential care facilities regulated by the *CCALA* and investigate complaints regarding this care.

The Office of the Assisted Living Registrar in the Ministry of Health oversees the regulation of assisted living residences and has the power to suspend, cancel or attach terms and conditions to a registration.

Hospital Act

Approximately thirty per cent of residential care facilities are private hospitals and extended care facilities licensed under the *Hospital Act*. The *Hospital Act* has changed very little over the past 50 years. While its principal focus has always been the regulation of public hospitals that provide acute, extended and rehabilitation care, the Act has also regulated private hospitals throughout this time. According to the definition set out in the *Hospital Insurance Act Regulations*, the prime function of extended care hospitals is the provision of “skilled nursing care and continuing medical supervision.”

Extended care hospitals have historically been attached to or associated with acute care hospitals. Most extended care facilities are operated by health authorities. However, extended care hospitals with religious affiliations continue to be operated in partnership with health authorities and in some cases under the direction of the Providence Health Care Society.

²⁴ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, s. 1.

Background

Private hospitals provide nursing care as well as treatment to people suffering from illness, disease or injury. The *Hospital Act* defines a “private hospital” as a house, sometimes referred to as a nursing home, in which two or more patients are receiving nursing care or other forms of treatment.²⁵ The definition of “patient” under the section of the Act dealing with private hospitals excludes a person who only requires “personal care” (defined as room and board, assistance with some daily activities, non-professional care, and social and recreational programs).²⁶

Under the Act, private hospitals must be approved as suitable for the purpose set out in their licensing application. The Minister of Health can specify conditions for the operation and management of a private hospital. However, unlike the *Residential Care Regulation*, the *Hospital Act* and the regulations made under it do not provide for any authority to establish mandatory standards for private hospitals.

Hospital Insurance Act and Hospital Insurance Act Regulations

The *Hospital Insurance Act* and *Hospital Insurance Act Regulations* establish the framework for how the provincial government funds health authorities to provide hospital services. The Act and regulations also define the services that an insured person is entitled to receive in a hospital setting, and when a person is required to pay fees.²⁷ General hospital services are available to any extended care patient who requires skilled nursing care and continuous medical supervision. General hospital services include services such as:

- necessary nursing services
- drugs, biologicals and related preparations
- laboratory and radiological procedures
- other services authorized by the minister

The *Continuing Care Act* also allows for the regulation of these services, and authorizes the Ministry of Health to establish binding quality and safety standards, determine applicable fees, appoint inspectors and enter into contracts with operators to provide services.

Continuing Care Act and Continuing Care Programs Regulation

Since January 2010, the *Continuing Care Act* and *Continuing Care Programs Regulation* has defined continuing care services for people with frailties, acute or chronic illnesses, or disabilities. These people do not require admission to an acute care hospital, but may need the following:

- home support services
- adult day services
- meal programs (including meals on wheels and congregate meal programs)
- continuing care respite services
- continuing care case management
- continuing care residential facilities

²⁵ *Hospital Act*, R.S.B.C. 1996, c. 200, s. 5(1).

²⁶ *Hospital Act*, R.S.B.C. 1996, c. 200, s. 5(1).

²⁷ *Hospital Insurance Act*, R.S.B.C. 1996, c. 204; *Hospital Insurance Act Regulations*, B.C. Reg. 25/61.

Background

- short stay assessment and treatment centres
- the home oxygen program
- assisted living services
- home care nursing
- community rehabilitation²⁸

Patient Care Quality Review Board Act

The *Patient Care Quality Review Board Act* came into force on October 15, 2008.²⁹ The Act creates a province-wide process for receiving and responding to complaints about the quality of health care. It requires each health authority to establish a patient care quality office to receive and process care quality complaints. According to the Act, a “care quality complaint” is a complaint about the delivery of, or the failure to deliver, health care (or a related service) or about the quality of health care (or a related service) delivered.³⁰ The Act also establishes a patient care quality review board in each health authority. People who continue to be dissatisfied after the patient care quality office in their region has investigated their complaint can request a further review by the local review board.

Legislation Not In Force

To become provincial law, a bill must receive both a majority vote of the legislative assembly and royal assent. The government has to take action to seek royal assent to all or part of a bill that has been passed by the Legislature. A bill that passes the Legislature but does not receive royal assent is legislation that is “not in force.” Not in force legislation has no effect and is not binding. The provisions discussed below are portions of legislation relating to seniors’ care that are not in force. They are discussed in more detail in the Assisted Living and Residential Care sections of the report.

Section 12 of the *Community Care and Assisted Living Act*

After the *Community Care and Assisted Living Act* was passed in 2002, the effective date of the legislation was delayed for nearly two years. While most of the Act eventually came into force in May 2004, section 12 was not included.

If section 12 were in force, it would bring all facilities that provide residential care, including private hospitals and extended care hospitals, under the governance of the *Community Care and Assisted Living Act* and the *Residential Care Regulation*. The effect of this would be to subject all extended care hospitals and private hospitals to the same rules and standards that apply to other residential care facilities in British Columbia.

²⁸ *Continuing Care Act*, R.S.B.C. 1996, c. 70, s. 3; *Continuing Care Programs Regulation*, B.C. Reg. 146/95, s. 1.

²⁹ *Patient Care Quality Review Board Act*, S.B.C. 2008, c. 35.

³⁰ *Patient Care Quality Review Board Act*, S.B.C. 2008, c. 35, s. 1.

Background

Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act*

The *Health Care (Consent) and Care Facility (Admission) Act* establishes a process for obtaining valid consent to health care when a patient is not capable of making such a decision.³¹ Part 3 of the Act sets out a similar process specifically for obtaining consent for admission to a care facility. More specifically, it sets out the circumstances under which substitute consent can be given together with the rights and duties of a person who gives substitute consent.

Various sections of the *Tenancy Statutes Amendment Act, 2006*

In 2006, amendments were made to the *Residential Tenancy Act* that have not yet been brought into force. These amendments set out processes for dispute resolution and procedures for ending tenancies in supportive housing settings and assisted living residences. They also address the administration of services provided in these situations. In the absence of these amendments, the only protection that assisted living and supportive housing residents have is through the occupancy agreements they sign with the operators of their facilities, as well as general consumer protection legislation, such as the regulation of deceptive practices, unconscionable acts and misleading advertising. If proclaimed, these amendments would create rights for assisted living and supportive housing tenants that they do not currently have.

Provincial Programs and Services for Seniors Who Need Care

A very broad range of provincial services and programs support seniors who need some form of care but do not require acute hospital-based care. Over the years, the range of services has had many different names, including “long-term care” and “continuing care.” Currently, the Ministry of Health and the health authorities refer to this set of services as “home and community care.”

While the focus of this report is on home support, assisted living and residential care, this section provides a brief overview of the many programs and services available to eligible seniors through the home and community care programs delivered by the health authorities.

Community-Based Programs

Home Support

Home support workers primarily provide personal assistance with daily activities such as bathing, dressing and grooming. Home support services are meant to help people stay in their own homes for as long as possible.

The health authorities provide subsidized home support services to people they deem eligible for care. People who are not eligible, or who do not wish to seek subsidized services, may also choose to hire home support workers at their own expense.

³¹ As modified by the *Health Statutes Amendment Act*, S.B.C. 2007, c. 19.

Background

Choice in Supports for Independent Living

The Choice in Supports for Independent Living (CSIL) program allows eligible people to manage their own home support services. Generally, home support services are either provided directly by the health authority, or by a company under contract with the health authority. In the CSIL program, the health authorities instead provide home support funding directly to seniors who are capable of managing their own services.³² Such seniors are then responsible for hiring, scheduling and supervising their home support workers.

Home Care

Home care differs from home support in that the services provided are medical rather than personal in nature. Health care professionals such as nurses and physical or occupational therapists deliver these services to clients in their own homes.³³ When similar services are provided to residents of care facilities, they are not considered to be home care. Nursing and rehabilitation services are provided free of charge.³⁴

Caregiver Relief and Respite

Respite care allows informal caregivers, who are usually family members, to take a break from their caregiving duties. Respite care can be provided in a client's home or through short-term admission to a residential care facility, hospice or other community care setting.

Adult Day Centres

For seniors who live in their homes, participating in adult day programs in community centres provides the opportunity to socialize with peers, access health services and get help with personal care needs, such as taking medications or bathing. Sometimes adult day centres also provide respite care for seniors, as well as transportation to and from the centre.

Supportive and Other Housing Programs

A range of provincial housing and health programs available to seniors in British Columbia provide varying types and levels of support, ranging from rent supplements — where no care is provided — to housing that includes services such as meal preparation, housekeeping and sometimes even 24-hour professional supervision.

In the course of our investigation, many people who were seeking access to housing programs told us they were confused by the variety of programs and their different names. They were unsure about the eligibility criteria for different services and did not know how to determine which ones were most appropriate. People were also unclear about how the various programs differed from one another. The terms

Seniors in British Columbia would benefit from plain language information regarding the entire spectrum of housing options for seniors and consistent use of terminology for the various housing options.

³² The CSIL program is available to any person 19 years or older and is primarily used by younger people.

³³ Ministry of Health, *Home and Community Care: A Guide to Your Care*, 2007, 5.

³⁴ Ministry of Health, *Home and Community Care: A Guide to Your Care*, 2007, 5.

Background

“supportive living,” “assisted living” and “independent living” caused the most confusion. The uncertainty seems due in large part to the existence of multiple programs with similar names and to the inconsistent use of terminology by the public and private organizations involved in delivering those programs.

Facility-Based Programs

Assisted Living

Assisted living is intended for people who can no longer live safely on their own, but who do not require the level of care and supervision provided in a residential care facility or private hospital. The *Community Care and Assisted Living Act (CCALA)* requires assisted living residences to be registered with the Office of the Assisted Living Registrar. Publicly subsidized assisted living services are provided in residences that are owned and operated by health authorities or by private agencies contracted to health authorities and operating on either a for-profit or a non-profit basis. Those who can afford to do so may also pay for a unit in an assisted living residence privately, using their own funds.

The *Community Care and Assisted Living Act* requires that a senior must be able to make decisions on his or her own behalf in order to be eligible to live in an assisted living residence. This is defined by Ministry of Health policy as being able to make decisions that will allow a person to function safely in the residence. According to the *CCALA*, exceptions are possible for spouses who live together in assisted living if one spouse is willing and able to make decisions on the other's behalf.³⁵

Residential Care

In addition to housing and all meals, residential care facilities provide a protective environment with 24-hour professional care and supervision. Residential care is meant for people who have complex care needs and who can no longer be cared for in their own homes. Residential care may be provided in community care facilities governed by the *Community Care and Assisted Living Act* or in private hospitals or extended care hospitals that are governed by the *Hospital Act*. Most extended care hospitals are owned and operated by a health authority. They are often located on the grounds of, or very near to, an acute care hospital. A small number of extended care hospitals are operated by private agencies. The Ministry of Health has indicated that it expects seniors to receive the same level and type of services whether care is provided in a community care facility, a private hospital or an extended care hospital.

Publicly subsidized residential care can be provided in facilities that are owned and operated by health authorities or by private agencies (both for-profit and non-profit). In order to be eligible for subsidized residential care, a person must first be assessed by a health authority as in need of this service. Those who have not been assessed as requiring residential care by a health authority and who can afford to do so may also pay for a bed or room in a residential care facility privately, using their own funds.

³⁵ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, s. 26(6).

Background

Palliative Care

Palliative care refers to the specialized care that is intended to relieve the suffering of those facing imminent death due to active, progressive and advanced diseases. Health care professionals and other unregulated care providers such as care aides and community health workers provide these services. Care can be provided in a patient's home, or in a residential care facility, hospital or hospice. These services are sometimes provided by health authorities and sometimes by non-profit societies.

For seniors living at home, the BC Palliative Care Benefits Program covers the cost of medications required for end-of-life care through the PharmaCare BC Palliative Care Drug Program. It also covers the cost of medical supplies and equipment, in cooperation with the health authorities. These benefits are available to individuals of any age who:

- have been diagnosed with a life-threatening illness or condition
- have a life expectancy of up to six months
- consent to the focus of their care being palliative rather than curative
- are living at home (defined as any place not covered under PharmaCare Plan B, which covers residential care and hospice services, but not extended care or assisted living)

A person must be enrolled in the Medical Services Plan (MSP) in order to be eligible for this program. Applicants must have their eligibility assessed by their doctor, who will then submit the application on their behalf.³⁶

Our Investigative Process

Origins of Investigation

In early 2008, while conducting outreach tours and giving presentations throughout the province, the Ombudsperson heard many comments about care for seniors in British Columbia. As a result, she issued a news release on June 26, 2008, asking anyone with concerns about seniors' care that had not been reasonably and fairly addressed by provincial authorities to contact the Office of the Ombudsperson. Following the news release, our office received a significant number of complaints from across the province about the services provided to seniors.

On August 21, 2008, the Ombudsperson initiated a province-wide investigation into the care provided to seniors, including home support, assisted living and residential care services. The decision to launch a systemic investigation was prompted in part by concerns about the vulnerability of seniors in care facilities. In addition, the Ombudsperson recognized that not all seniors have loved ones available to provide advocacy and support, and that seniors with physical and mental challenges may experience difficulty in raising concerns.

³⁶ People who are not enrolled in MSP but meet the other eligibility criteria for palliative benefits may receive access to the benefits after PharmaCare reviews and accepts their application to designate benefits by Special Authorities.

Background

In December 2009, the Office of the Ombudsperson completed its first phase of reporting on seniors' care with the release of the *Best of Care: Getting It Right for Seniors in British Columbia (Part I)*. This report addressed three major issues related to residential care services: residents' rights, public information and reporting, and resident and family councils. The current report considers a broader scope of issues related to the care of seniors receiving home support, assisted living and residential care services.

Issues Considered

Ombudsperson staff considered a number of issues in the course of this investigation, including:

- access to publicly available information
- access to services
- collecting, managing and reporting of information
- complaints processes
- facility closures
- fees for services
- funding processes
- quality of care
- monitoring and enforcement
- placement processes
- staff qualifications and training

Document Review

In the course of the seniors' care investigation, Ombudsperson staff reviewed documents obtained from the health authorities and provided to our office by the public and other interested organizations. Information reviewed included:

- legislation, regulation and policies
- government letters of expectations
- international, national and provincial documents that establish basic principles and standards for the care of seniors
- guidelines, directives and bulletins
- statistics related to the population of seniors in B.C.
- organizational charts and job descriptions
- program descriptions, policies, guidelines and public information
- handbooks, brochures, booklets and online information about home and community care
- information about programs and services offered in other jurisdictions
- service agreements between health authorities and contracted service agencies
- reports about seniors' care in B.C. and other jurisdictions

Background

Meetings and Consultations

At the outset of the investigation, our office held individual meetings with the Ministry of Health Services and the Ministry of Healthy Living and Sport and with the five regional health authorities to hear about their respective roles and responsibilities, organizational structures, and the policies and processes in place for the delivery and monitoring of care for seniors. These initial meetings were followed by requests for in-depth information, and led to further meetings and consultations throughout the investigation. As the investigation progressed, our team also met with several other individuals and government agencies, including the public guardian and trustee, Treasury Board staff and the Seniors' Healthy Living Secretariat.

In addition, we received information and presentations from with over 40 societies, councils, networks, associations, unions, university centres and other organizations.

Ombudsperson Site Visits

Our investigation team toured the five health authorities, visiting over 50 residential care and assisted living facilities across the province (approximately 10 facilities in each health authority). To the extent possible, we visited a cross-section of facilities located in rural, suburban and urban areas within each health authority. The selected care facilities also covered a variety of care types, including complex care, special care, transitional care, palliative care, extended care, acute care and assisted living.

Each facility was systematically reviewed to assess the type of facility, funding arrangements, charges to residents, care services, staffing information, resident and family representation, and monitoring and complaints processes. The observations and information collected during the site visits provided additional data for comparing care facilities for seniors in the different health authorities.

File Reviews

During the investigation, our team conducted reviews of:

- 35 per cent of the complaint files involving the care of seniors that the patient care quality offices received between October 2008 and June 2009
- reviews involving care of seniors completed by the patient care quality review boards between October 2008 and June 2010
- decisions dealing with residential care facilities considered by the Community Care and Assisted Living Appeal Board since its inception
- a representative random selection of files documenting complaints received by the Office of the Assisted Living Registrar from 2007 to 2009
- a representative random selection of the Office of the Assisted Living Registrar's site inspection files
- licensing complaints about 15 facilities operating under the *Community Care and Assisted Living Act* (three from each health authority) received between July 1, 2007, and July 1, 2009
- a representative random sample of inspection reports from 30 residential care facilities in each of the 5 health authorities from the period of January 2008 to June 2010 inclusive

Background

Public Input

The public response since the launching of this investigation has been impressive both in terms of the level of interest and in the variety of perspectives brought to the understanding of seniors' care issues. In the course of our investigation, we have received input from seniors, families and friends of seniors, family councils, advocacy groups, care providers, unions, private consultants and academics.

The public provided input in a number of ways: by answering an online questionnaire and by writing to the Ombudsperson to share their experiences and concerns. In total, the Ombudsperson heard from over 700 people. In addition, the Ombudsperson received over 250 complaints about home support, assisted living and residential care since initiating the investigation.

Most of the individuals and organizations we consulted with were very supportive of our investigation, and responded to our requests for information in a timely, open and straightforward fashion.

We would like to thank everyone who took the time to meet with us, answer our questions and provide input for this investigation.



Home and Community Care

This report examines three key types of health services for seniors: home support, assisted living and residential care. Many of the issues and concerns about these services overlap and we deal with those common issues in this section.

Funding

As with any other provincial government program, the delivery of home and community care services is dependent on the funding available for that program. The provincial government makes decisions about funding for programs and services as part of its overall budgeting process, which involves different ministries and agencies. The role each of these bodies plays in that process is described below.

Role of the Treasury Board

The Treasury Board is a statutory committee of cabinet that is responsible for overseeing the provincial budgeting process. It is chaired by the Minister of Finance. When creating the annual budget, the Treasury Board sets aside money for the government's current priorities and new initiatives, as well as funds for the ongoing operations of each sector. Once the Treasury Board has developed the annual budget for the coming fiscal year, the Minister of Finance introduces it in the legislative assembly for debate and approval. This usually occurs in February. The annual debate of the budget "estimates" is a line-by-line examination of all spending proposed in the budget, which eventually leads to the adoption of the year's budget by the legislative assembly.

Spending estimates are usually based on the current year's budget, although economic changes may affect the estimates. In a normal budget cycle, the provincial government decides its priorities for the coming year based on information from a number of sources. In the months leading up to the budget, financial and economic forecasts are used to project revenues for the next fiscal year, and these projections are a cornerstone of the budgeting process.

The government may require a ministry to factor in funding for a new initiative into its budget. The government may, for example, decide that it is going to earmark funds to be used to reduce waiting times for a certain surgical procedure or to increase the number of residential care beds. At the same time, the

Population Needs-Based Funding

In the early 1990s, the Royal Commission on Health Care and Costs recommended the distribution of funds to health regions using a formula based on the relative need for health services of that region's population. This led to the development of the population needs-based funding model that is still used today in British Columbia. Other countries and Canadian provinces have since adopted similar models.

The objective of the model is to identify the funding required by each health authority, based on the characteristics and needs of its population. Using regional demographic data, the model adjusts for the age and socio-economic status of individuals in the region. The model also accounts for waiting times to access services and standards of care.

Source: Ministry of Health Services,
Population Needs-Based Funding Model,
December 2008.

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government may invite ministries to develop their own proposals for spending specific amounts of money. In times of changing government priorities or economic restraint, ministries might also be asked how they would spend their money if their budgets were reduced.

Discussion of government spending usually refers to the concept of “envelopes.” Money is set aside in specific envelopes to fund various sectors. The health sector has its own envelope, along with areas such as education, public safety and natural resources.

When it comes to making decisions about health care spending, the role of the Treasury Board is very broad. The Treasury Board determines the overall budget figure for the Ministry of Health, but it does not specify how much funding should go to each health authority or to individual programs, although it may earmark funds for a specific purpose.

Role of the Ministry of Health

Like all ministries, the Ministry of Health prepares its annual budget submission according to the Treasury Board’s requirements. Home and community care, which includes home support, assisted living and residential care, is one component of health spending. Other programs and services the ministry must provide for include acute care, mental health, public health protection and other services. While it is the health authorities that actually deliver these programs, it is the ministry’s responsibility to ensure that they are adequately planned for and funded. It does this by gathering and analyzing information supplied by the health authorities.

After submitting its proposed budget, the ministry makes a series of presentations to the Treasury Board in support of its request. Health authorities do not make presentations to Treasury Board as part of the budget process. They were invited to participate on only one occasion.

When the Ministry of Health is notified of the Treasury Board’s decision on its budget, it then decides how much each health authority will receive. The ministry uses a population needs-based funding model to determine this amount at the preliminary stage. Population needs-based funding is applied to the figure set aside for health authority funding. It is a way to determine the portion of the total health authority funding that each region will receive, based on the characteristics and needs of the region. It is not a guarantee that the actual needs will be funded. This means that there may be differences between the funding the health authorities request and the amount they receive. Follow-up discussions with the health authorities then lead to final budget allocations for the fiscal year. The ministry does not play a direct role in determining how funds, other than those targeted for specific new initiatives, are allocated within each health authority.

The framework for the ongoing relationship between the ministry and each health authority is established by the Government Letter of Expectations (GLE) that each health authority receives from the ministry. These letters are prepared as annual agreements between the ministry and health authorities, and they take effect on April 1 each year. The purpose of the GLE is to establish:

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an agreement on the accountabilities, roles and responsibilities of both parties with respect to the planning, administration, delivery and monitoring of health services. The GLE articulates high level performance expectations and strategic priorities, and is the basis for Health Authority service planning and performance reporting to Government.³⁷

The GLE includes planning and reporting obligations and can also set out specific actions to be undertaken by a health authority. An example of a specific action is the number of new residential care beds and assisted living beds the ministry expects the health authority to open during that budget year.

What appears to be absent in the health sector envelope and population needs-based funding model is a mechanism to forecast needs and monitor whether the specific programs within the health authorities actually receive adequate funding to meet the health and care needs of those they are intended to serve and the health authorities' ability to meet the objectives established by the ministry.

Role of the Health Authorities

Each health authority prepares a detailed annual budget request for the ministry that outlines its spending proposals for the coming year. This request is sent to the ministry in October or November for the upcoming budget year — April 1 to March 31. Health authorities do not assist the ministry in preparing submissions for Treasury Board.

Once the ministry informs each health authority of its individual budgets, the health authority then decides how to distribute the funding it will actually receive to each major program area, including acute care and home and community care. The health authorities develop plans for projected spending in each sector.

Planning Framework

It is important that the Ministry of Health and the health authorities monitor the demand for home and community care services in order to plan for future funding needs and to ensure that those eligible for services are able to receive them in a timely manner. We asked the Ministry of Health and the health authorities how they determined whether the funding provided is sufficient to meet the demand for subsidized home and community care services. In November 2011, the Fraser Health Authority told us that it monitors the demand for these services annually and takes the increased demand into consideration in its annual budget and financial planning decision making. Neither the Ministry of Health nor the other health authorities provided us with any evidence that they monitor the demand for subsidized home and community care services to determine whether the funding provided is sufficient. Clearly, this challenges the ability of the Ministry of Health to evaluate and forecast the need for home and community care services.

In October 2008, the Office of the Auditor General of British Columbia released a report called *Home and Community Care Services: Meeting Needs and Preparing for the Future* that examined whether the then-Ministry of Health Services was ensuring that the home and community care system had the capacity to meet the needs of the province's residents.³⁸ One of the Auditor General's key conclusions

³⁷ Minister of Health Services, Government Letter of Expectations to the health authorities, unsigned copy provided October 2009, 1.

³⁸ Office of the Auditor General of British Columbia, *Home and Community Care Services: Meeting Needs and Preparing for the Future*, October 2008.

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was that the ministry did not have a comprehensive planning framework for home and community care. The report stressed that “the ministry must work with the health authorities to ensure that the right types of services, the right number of appropriately equipped units or beds, and an adequate supply of qualified caregivers and health care professionals are all in place to meet the needs of the aging population and others who use the system.”³⁹

The Auditor General recommended that the ministry have a framework that allows for the coordination of health authority planning for capital, human resources and information technology spending.⁴⁰ He commented on the importance of having a process for evaluating and forecasting needs and demands, and developing a multi-year capacity plan.⁴¹

The Auditor General also recommended that the ministry develop capacity indicators for all home and community care programs and services, incorporate information on costs and population needs into program planning, and coordinate its research and evaluation cycle with the health authorities.⁴² We view these recommendations to be sound and relevant, and, as a result, have chosen not to issue our own findings and recommendations in this area.

The overall issue of the adequacy of funding for community care services is one for the legislative assembly, the Treasury Board, the Ministry of Health and the health authorities to resolve. It will be hard, however, to address the other challenges in service delivery unless there is a clear process for evaluating and forecasting needs, a plan for the resources required to meet those needs, tracking of the funding assigned to home and community care service delivery, and evaluation and reporting of the results that funding produces.

Along with better planning, there is also a need for greater transparency in the funding process for home and community care. In his report, the Auditor General noted the need for the Ministry of Health to increase its accountability to the public through more comprehensive performance reporting. In addition to keeping the public informed on how the home and community care system is performing, the ministry also has a responsibility to provide the public with clear, accessible and easily understandable information about the money being invested into the system and the results being provided. Part of the ministry’s stewardship role is to ensure that funding is assigned for specific purposes and is expended to produce specific results. Providing reliable and consistent information on an ongoing basis about the funding of home and community care services as well as the resulting outcomes will allow the public to evaluate the adequacy of available services. It may also make public discussion of the financial realities faced by the ministry and the health authorities more informed. Reporting this information publicly also reflects a fundamental respect for the people and taxpayers who are the users and funders of this system.

³⁹ Office of the Auditor General of British Columbia, *Home and Community Care Services*, 2008, 8.

⁴⁰ Office of the Auditor General of British Columbia, *Home and Community Care Services*, 2008, 39.

⁴¹ Office of the Auditor General of British Columbia, *Home and Community Care Services*, 2008, 8-9.

⁴² Office of the Auditor General of British Columbia, *Home and Community Care Services*, 2008, 45.

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The Ombudsperson finds that

- F1. The Ministry of Health does not track and report publicly on the funding allocated to and expended on home and community care services and the results achieved.

The Ombudsperson recommends that

- R1. The Ministry of Health report publicly on an annual basis in a way that is clear and accessible:
- the funding allocated to home and community care services by each health authority
 - the funds expended on home and community care services in each health authority
 - the planned results for home and community care services in each health authority
 - the actual results delivered by home and community care services
 - an explanation of any differences between the planned results and the actual results

Difficulties in Obtaining Information

While people were responsive to our requests for information during our investigation, we encountered difficulties in gathering comprehensive, consistent and reliable information from the health authorities and the Ministry of Health. In many cases, the information we requested simply was not tracked. We were, for example, unable to obtain information on the length of time it takes for clients to begin receiving home support services after being assessed and approved for those services by the health authorities.

In some cases, the information we requested was tracked but not broken down into relevant categories. For example, the health authorities track overall waiting times for placement in subsidized residential care. However, they do not separately track how long seniors wait for placement depending on whether they are waiting at home, in assisted living, in another residential care facility or in hospital, all of which can be different depending on the health authority's policies. Other information was not available on a regional or provincial level, either because it is recorded only in individual case files and not tracked in a central location (for example, information about investigations of abuse or neglect conducted under the *Adult Guardianship Act*), or because the ministry does not collect the relevant data from the health authorities (for example, information about exemptions granted to residential care operators from the requirements of the *Community Care and Assisted Living Act (CCALA)* or the *Residential Care Regulation*).

We also received information that was incomplete or contradictory. Incomplete submissions created particular challenges in obtaining accurate information about the number of seniors receiving subsidized home support services and the hours of service provided between 2002/03 and 2009/10. The Vancouver Coastal Health Authority was unable to provide us with home support data specific to seniors;⁴³ the Interior Health Authority could not provide the number of home support hours from 2002/03 to 2004/05; and the Northern Health Authority could not access the requested data because it was stored in the Ministry of Health's data warehouse once it was entered into the continuing care information management system

⁴³ In November 2011, the Vancouver Coastal Health Authority reported that it tracks home support data, and once implementation issues are addressed with its information system, it will be able to report this type of information.

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(CCIMS). When we asked the Ministry of Health for this information, it provided data for each health authority for each of the years requested but told us that due to incomplete data submissions by Interior Health and Vancouver Coastal Health, some data might be unreliable for 2008/09 and 2009/10.

We also received information that varied inexplicably depending on the source or the time when the information was submitted. In some cases, information was reported inconsistently from within an organization. For example, when we sent sequential requests for information related to residential care facilities, the number of licensed facilities reported by some of the health authorities varied from one response to another even though they covered the same time frame. Inconsistencies also arose between information provided by the health authorities and the Ministry of Health. When we asked for information about the total number of clients in publicly subsidized residential care beds between 2002/03 and 2008/09, for example, there were significant differences between the figures provided for each health authority by the ministry and those provided by all of the health authorities, except for the Vancouver Island Health Authority (VIHA) whose data matched the ministry's data exactly.

The Ombudsperson finds that

- F2. The Ministry of Health and the health authorities were unable to provide consistent and reliable data about home and community care services.

The Ombudsperson recommends that

- R2. The Ministry of Health work with the health authorities and other stakeholders to identify key home and community care data that should be tracked by the health authorities and reported to the ministry on a quarterly basis.
- R3. The Ministry of Health include the reported data in an annual home and community care report that it makes publicly available.

Collecting, Managing and Reporting Information

To successfully fulfill its role as the steward of the health care system in British Columbia, the Ministry of Health needs to set standards and monitor and evaluate the performance of the health authorities. In order to do this, the ministry needs to have consistent, reliable data from the health authorities who are responsible for service delivery. Collection and management of health-related information by the ministry is an essential part of its stewardship role and requires the ministry to have a comprehensive and reliable information management system.

The ministry also reports information about home and community care to the Canadian Institute for Health Information (CIHI). The CIHI is a stand-alone agency created by federal, provincial and territorial governments to collect, analyze and report on Canadian health data.⁴⁴ This information is used in the development of public policy by government bodies, hospitals, health authorities and professional associations.

⁴⁴ For more information, see CIHI's website <www.cihi.ca>.

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Ensuring that the public has access to information about health services is another critical role for the Ministry of Health. Many British Columbians, including taxpayers, residents, academics and health policy researchers, are interested in knowing how effectively our health care system is operating.

The following are the main categories of information that are currently reported to the ministry and that are available for its use in making policy and funding decisions:

- demographic (for example, age, residence, gender and marital status, as well as whether a person is of aboriginal origin or a veteran of the armed forces)
- clinical (for example, individual care needs, the degree of independence, the extent of cognitive impairments)
- service episode (for example, when a particular service started or ended, who provided the service, where and how often)
- client charges (for example, the amounts charged for services, such as accommodation and hospitality fees for residential care and assisted living)

"An important application of data collected within the home and community care sector is to support the evaluation of policy."

Source: University of British Columbia, Centre for Health Services and Policy Research.

Transition to the Minimum Reporting Requirements System

Since 1978, the provincial government has used a complex database known as the continuing care information management system (CCIMS). The CCIMS is considered a "legacy system," meaning it was written in computer code that is now outdated. The original purpose of the CCIMS was to allow service providers to bill the ministry for work done. Over time, the system was adapted so that it could also track information about home and community care clients and the services they receive.

The ministry and health authorities began planning strategies to address the need for replacement of the old CCIMS data system in the 1990s due to its age and the risk of failure. Prior to 2005, the ministry determined that it had outgrown the capabilities of the CCIMS and that it needed a new way to manage information in order to provide proper program funding, planning and evaluation.⁴⁵ However, the health authorities said they wanted to develop their own systems for managing home and community care information and the ministry agreed to let them do so. Consequently, the ministry decided not to implement a new province-wide information system. Since the ministry still required reliable and consistent information to carry out its oversight and planning roles, it then worked with the health authorities to establish a set of minimum reporting requirements for home and community care. The way health authorities report information to the Ministry of Health has been in transition for the past five years.

The type of information collected and tracked under the minimum reporting requirements (MRR) system differs in some cases from that collected and tracked under the CCIMS. For example, under the MRR system, the location of services must be reported, which was not the case under the CCIMS.

⁴⁵ Office of the Auditor General of British Columbia, *Follow-up Report: Updates on the Implementation of Recommendations from Recent Reports*, April 2010, 79.

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While the MRR system, once fully operational, will provide more useful and timely information than the CCIMS, the transition has proved problematic. One reason is that when the health authorities first began to make the transition, the ministry did not continue to require them to report through the CCIMS. This resulted in gaps in the information the ministry received. For example, the Interior Health Authority, which was the first health authority to begin the transition, was not required by the ministry to continue reporting through the CCIMS once it started its transition. As a result of this change in reporting requirements for Interior Health, the ministry did not receive its data for 2006/07 and 2007/08 until late 2009.⁴⁶ The ministry now requires the other health authorities to continue to report through the CCIMS until their transition is complete.

In the Auditor General's October 2008 report on home and community care services, he noted the importance of information management:

It is also critical that the ministry has high quality information to support the most efficient and effective allocation of resources and to provide relevant and reliable information to the public and key stakeholders on the capacity of the system to deliver required services. Although the ministry has taken steps to improve the level and quality of information used for planning, monitoring and reporting, more work is needed.⁴⁷

The Auditor General commented on the fact that while the ministry had clearly set out its requirements for information reporting, "the management information system used to collect and report information from the health authorities is not meeting the ministry's needs."⁴⁸

The Auditor General's report included two recommendations on information management. First, the ministry should work with the health authorities to finalize a comprehensive plan for managing information systems, including key priorities, timelines and expectations for replacing the current system. Second, the ministry should "improve the documentation of roles, responsibilities and

Examples of Minimum Reporting Requirements:

- amount of service hours provided
- number of face-to-face service visits
- number of remote (no face-to-face) service visits
- number of days of service provided

Source: Ministry of Health, letter to the Office of the Ombudsperson, December 15, 2008.

Difficulties with the Continuing Care Information Management System

Throughout this report are examples of information the Northern Health Authority was not able to provide to our office. For example, Northern Health informed our office that it does not have direct access to the statistical data that it reported to the Ministry of Health through the CCIMS and that if we were interested in the data the Ministry of Health could provide it to us. Northern Health believes the new MMR system will improve its ability to store and retrieve data. This will not, however, include information provided prior to the transition to the MRR system.

⁴⁶ Office of the Auditor General of British Columbia, *Home and Community Care Services*, 2008, 37.

⁴⁷ Office of the Auditor General of British Columbia, *Home and Community Care Services*, 2008, 1.

⁴⁸ Office of the Auditor General of British Columbia, *Home and Community Care Services*, 2008, 7.

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processes for data quality.”⁴⁹ Since the release of this report, the Ministry of Health has reported twice to the Auditor General with a self-assessment of the progress made in meeting these two recommendations. In July 2009, the ministry indicated that it considered all of the elements to be substantially or partially implemented for the first recommendation, depending on the progress made by each of the health authorities in transitioning to the new MRR system. The ministry considered the second recommendation to be substantially implemented because it had established an information management committee to work collaboratively with the health authorities on data management issues, which led to revised specifications for the minimum reporting requirements. In January 2010, the ministry reported that the first recommendation was still “partially implemented” because two of the five health authorities were not expected to complete the retirement of the CCIMS and transfer to the new MRR system in 2010/11.

In February 2009, the former Minister of Health Services sent a directive to the health authorities that set the following deadlines for their transition to the MRR system:

- By May 1, 2009: Complete the identification of any health authority’s specific barriers to full compliance that would require collaboration between the ministry and health authorities to resolve.
- By December 1, 2009: Ensure full compliance with data reporting, as outlined in the home and community care MRR system specifications.⁵⁰

Interior Health, Northern Health and Vancouver Coastal Health have transitioned from the CCIMS and are providing data through the MRR system. However, none of these three health authorities met the ministry’s deadline for full compliance with data reporting. The remaining two health authorities are still in transition and believe they will be fully compliant with the MRR system by April 1, 2012.

Meanwhile, the old CCIMS does not provide easy access or quick retrieval of information and lacks the flexibility to keep up with changes in service delivery. This poses problems for the ministry and the health authorities that have not fully transitioned to the MRR system because, as the ministry acknowledges, technical support is no longer readily available for the CCIMS. Maintaining the CCIMS has become more complicated and costly.⁵¹

Conclusion

The health authorities were established in their current form in December 2001. Since that time, each has worked to update the information systems within its own region but generally without provincially mandated standards or direction. As a result, the health authorities have adopted a variety of approaches to this work, which are often based primarily on costs and considerations of adapting existing systems. Some health authorities have adopted comprehensive and integrated systems for managing home and community care information. Others have multiple, separate software programs for handling different types of information, such as that on assessments, scheduling and client registration.

⁴⁹ Office of the Auditor General of British Columbia, *Home and Community Care Services*, 2008, 38.

⁵⁰ Minister of Health Services, *Home and Community Care Quality and Performance Monitoring*, 27 February 2009. The directive was issued pursuant to the 2008/09 government letters of expectations sent by the minister to the board chairs of each of the five regional health authorities. This document is cited subsequently in this report as the “Ministry of Health directive, February 2009.”

⁵¹ Office of the Auditor General of British Columbia, *Home and Community Care Services*, 2008, 36.

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When the ministry decided in 2005 to transition from the CCIMS to a new information management system, it missed an opportunity to remedy those problems. It allowed the health authorities to develop their own systems, as long as they complied with the ministry's new minimum reporting requirements. It also allowed Interior Health to stop reporting through the CCIMS during its transition to the MRR system. These decisions led to challenges in implementing the MRR system within a reasonable time frame and to gaps in reporting.

Information management or technology upgrades usually require significant investment, which makes adequate oversight of these projects especially important. However, in the case of the transition to the MRR system, the ministry did not ensure that delays were resolved in a timely way. The ministry set a deadline for the health authorities and had to continually extend it. Given how expensive this type of technology is to create, maintain and operate, a more consistent provincial approach to information management would have been more efficient and effective.

The ministry could improve its information management processes by working with the health authorities to better manage transitions to new information technologies in the future. Before new initiatives are considered, the ministry and the health authorities should:

- assess the technical and financial requirements before beginning a process or setting timelines
- consider the need for consistency and interconnectivity between all the health authorities
- consider the need for effective communication between the parties to facilitate coordinated activity
- provide realistic timelines and clear performance measures to track progress during the transition
- ensure that differing information management systems are compatible with the ministry's standards and with other health authorities
- create a backup plan in case the transition doesn't go as scheduled

Given that the ministry decided to transition to the MRR system in 2005 because the CCMIS lacked key information, the fact that the system is still not fully functional more than five years later is a serious concern. The ministry needs accurate, timely and comprehensive information in order to carry out its responsibilities to plan, monitor, assess and set standards for the delivery of home and community care services. The absence of timely, reliable and accessible data interferes with the ministry's ability to carry out its important role in planning, stewardship and oversight.

The Ombudsperson finds that

- F3. In 2005, the Ministry of Health identified that it needed a new data reporting system to collect and manage home and community care information, but the new system is not yet fully operational.

The Ombudsperson recommends that

- R4. The Ministry of Health ensure that all health authorities are reliably reporting all the information required by the minimum reporting requirements (MRR) by May 31, 2012.

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The Ombudsperson finds that

- F4. None of the health authorities met the December 1, 2009, deadline that the Ministry of Health set for them to switch to the new MRR system.

The Ombudsperson recommends that

- R5. The health authorities ensure that the MRR system is fully operational in their regions by May 31, 2012.

The Ombudsperson finds that

- F5. The process selected by the Ministry of Health to move to the MRR system allowed gaps in the reporting of information required by the ministry.

The Ombudsperson recommends that

- R6. The Ministry of Health, when developing a new information management system, ensure that the new system is fully operational before allowing information reported under the old system to be discontinued.

Eligibility, Assessment and Access

A fair, consistent and reasonable process for assessing eligibility and timely access to a program is an important aspect of administrative fairness. People seeking subsidized home support, assisted living or residential care services must apply to their health authority to have their need and eligibility assessed before they can begin receiving these services. The process of applying for services often begins when a friend, relative or health professional notices that a senior may need help. Often, these people will suggest that a senior get in touch with the regional health authority or a community agency, or they will initiate this contact themselves. The rules that apply to eligibility and access to subsidized home and community care services are contained in the Ministry of Health's *Home and Community Care Policy Manual*, not in law. This means that changes to eligibility criteria can be made by the ministry and do not require further approval. Over the course of this investigation, the ministry did make changes to its home and community care policies, including the eligibility criteria for services.

Once the health authority receives a referral, ministry policy states that it should contact the referred person within 72 hours to decide the nature and urgency of his or her health care needs.⁵² The stated purpose of the initial contact is to decide whether the health authority should conduct an assessment, refer the senior to community (that is non-government) resources or take no further action.

⁵² Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Referral and Intake, 2.C.1.

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To be eligible for subsidized home and community care services, a senior must:

- be a Canadian citizen or permanent resident, or have applied for permanent residence and been issued a Temporary Residence Permit on medical grounds by the federal government
- be a B.C. resident at the time of application and have lived in British Columbia for at least three months
- have an impaired ability to function independently because of chronic health conditions, require care following discharge from hospital, require home care rather than hospitalization, or require end-of-life care⁵³

As a further condition of receiving subsidized home and community care services, seniors must give their written consent allowing the ministry to obtain and verify their income from the Canada Revenue Agency.

Assessment Process

Assessment is an important part of the application process. Assessment is a clinical evaluation of care needs and is the basis on which the health authorities decide whether they will provide home and community care services to each person who applies and, if approved, the nature, level, amount, cost and duration of those services.

Since April 1, 2011, however, all assessments must be conducted by a “health professional,” which the ministry’s revised *Home and Community Care Policy Manual* defines as a registered nurse, registered psychiatric nurse, licensed practical nurse, occupational therapist, physiotherapist or social worker whose profession is regulated under the *Health Professions Act*.⁵⁴ Previously, ministry policy referred to the health authority staff who conduct assessments as “continuing care case managers.”⁵⁵

After a health authority receives a request or referral for home and community care services, one of its health professionals will conduct the assessment. Health authorities may differ as to which of their health professionals conduct assessments. Assessments for the Vancouver Island Health Authority and the Interior Health Authority are performed by hospital case managers and central intake clinicians: registered nurses with home and community care backgrounds. For the Northern Health Authority, assessments are conducted mostly by case managers who are registered nurses, though some are licensed practical nurses. Case managers for the Fraser Health Authority are registered nurses, physiotherapists, occupational therapists or social workers. Assessments for the Vancouver Coastal Health Authority are conducted by regulated health care professionals with qualifications from their particular professional college.

The Ministry of Health requires the health authorities to use a Canadian version of the interRAI set of assessment tools to evaluate risk factors and determine the appropriate levels of care for the seniors whose needs are being assessed (see text box).⁵⁶ In doing so, British Columbia has joined a wider community of jurisdictions that are adopting the interRAI tools. These tools were created by a group of international

⁵³ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Eligibility, 2.B.

⁵⁴ As of April 2011, there were 26 regulated health professions in B.C.

⁵⁵ Although it appears that most staff who previously conducted assessments are “health professionals,” there may be some staff who are no longer able to conduct assessments, because they do not meet this requirement.

⁵⁶ This requirement has been in effect since April 2005.

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researchers and practitioners and have the potential to improve the consistency and fairness of assessments. However, according to staff who use the tools, they add additional administrative work to the assessment process.

The purpose of the assessment is not only to confirm the need and eligibility for services, but also to devise a care plan for service delivery.⁵⁷ Family members can be present during in-person assessments if the applicant agrees to this. During the assessment, the health professional discusses the applicant's current situation and evaluates his or her overall needs, capability and potential. At the same time, the health professional also explores possible options or alternatives to health authority-funded provision of any required care services, including whether family and friends might be able to provide the necessary support. A key aspect of the assessment is that home and community care is seen, in accordance with policy, as supplementing not replacing assistance that family and friends are willing and able to provide. If family and friends are identified as capable of providing support, the senior's level of risk is assessed lower and may affect the timeliness and amount of service a senior receives.

According to Northern Health, Interior Health and Fraser Health, assessments are always done in person. Vancouver Coastal Health allows assessments to be done through a combination of telephone and in-person interviews. VIHA screens for service eligibility over the phone and conducts initial care planning assessments in person.

When assessing an applicant's risk level, health professionals use a scoring guide from the *Home and Community Care Case Management Handbook*.⁵⁸ Some of the factors included in this scoring guide are the person's level of cognitive functioning, need for help with daily activities and medications, level of mobility, and the availability of friends and family. Others include whether a senior has recently been admitted to acute care or has a limited ability to pay. Scores in each category range from one to three, with three indicating the highest risk level.

interRAI: The International Resident Assessment Instrument

interRAI is derived from "International Resident Assessment Instrument" and refers to various systems of instruments developed by an international network of gerontology researchers. The purpose of this tool is to promote "evidence-based clinical practice and policy decisions through the collection and interpretation of high quality data about the characteristics and outcomes of persons served across a variety of health and social services settings."

These researchers have now formed an organization known as interRAI that has developed instruments for a range of populations in various areas of health care, including home care, mental health, community mental health, people with intellectual disabilities and palliative care.

Source: interRai website
<<http://www.interrai.org/section/view/>>.

⁵⁷ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Assessment, 2.D.

⁵⁸ Ministry of Health Services, *Home and Community Care Case Management Handbook*, March 2006, Chapter 7: Criteria for Scoring Risk Factors for New Referrals for Case Management Services.

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After the assessment, the health professional will determine whether an applicant is eligible for subsidized services based on citizenship, residency, age, health condition, and whether a third party is obligated to support the applicant as the result of a legal proceeding.⁵⁹ If not, the health professional may provide a referral to services that the senior may wish to purchase privately. Applicants who are eligible for subsidized services will be told about the services they can receive and the costs that apply. Finally, and with input from seniors and their families, if the senior wishes, the health professional will develop a care plan. Care plans should include each senior's diagnoses, care needs, services required and treatment goals. Care plans should also account for each senior's abilities, physical, social and emotional needs, and cultural and spiritual preferences.⁶⁰ Health authority staff or contractors are then responsible for providing the services set out in each care plan.

Once a senior is receiving services, health authority staff will conduct reassessments to ensure that he or she still requires the services being provided and record any changes that have occurred since the previous visit. A reassessment may also be conducted at the request of the senior, service provider, family member, physician or other health care professional.⁶¹

Waiting to Be Assessed

Ministry policy states that assessments should be ranked on the urgency of the senior's health care needs, the availability of family or other caregivers and community support, the potential risk in the senior's present living situation, and the length of time the senior has been waiting for an assessment.⁶² The ministry's policy on assessment timelines is set out in the *RAI-HC Clinical Practice Standards and "Best Practice" Guidelines* (2006). These guidelines state that seniors should be assessed within two weeks of referral to a health authority.

While assessment within two weeks may be the goal, it is not always achieved. We received the following complaint about assessment waiting times from the daughter of Wilma, who already lived in a residential care facility. Wilma was paying the full costs herself because she had not yet been assessed. She had insurance that would have paid part of her costs, but to access this coverage, her regional health authority had to assess her as in need of residential care. (The name below has been changed to protect confidentiality.)

Wilma's Story

Wilma was 82 and living in a residential care facility in the Interior. She was paying the entire cost of her care herself and did not receive a subsidy from the Interior Health Authority. However, Wilma did have insurance that would have covered a substantial portion of her care costs, if she could show that her local health authority had assessed her as in need of residential care.

Wilma's daughter asked Interior Health to assess Wilma and was told that it would take a month for this to happen. When a month passed without an assessment, the daughter contacted us because she was worried that the delay was costing her mother a lot of money. When we contacted Interior Health, staff told us that the one-month estimate

⁵⁹ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Eligibility, 2.B, 1.

⁶⁰ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: General Description and Definitions, 2.A, 1.

⁶¹ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Assessment, 2.D.

⁶² Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Referral and Intake, 2.C.

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was not realistic for Wilma because assessments are ranked on health risk. Since Wilma's health needs were already being met, because she was in a residential care facility, she was a low priority for assessment. The Interior Health Authority also told us that it had 180 outstanding requests for assessment.

Wilma was finally assessed more than three months after her daughter had submitted her request. Only after the assessment was a substantial proportion of Wilma's care costs paid by her insurance.

As Wilma's story illustrates, waiting times for assessment can sometimes be quite lengthy. This is particularly the case if the health authority believes the senior is at low risk because family or friends are helping, or if a senior is already privately paying for care. Waiting times for assessment also vary by health authority.

As part of this investigation, ombudsperson staff asked each health authority to report on the number of people it had waiting for a home and community care assessment. Only Northern Health could report the number of people waiting for an assessment as of March 31, 2011. On that date, 19 people were awaiting an assessment. Northern Health told us that the average waiting time from referral to assessment in 2010/11 was 205 days, and that in some instances clients were receiving services on an interim basis until a formal assessment was completed. Due to a system upgrade, Interior Health was unable to provide information for its Kootenay Boundary area, but reported that as of March 31, 2011, there were 178 people awaiting assessment in the rest of the health authority. The average waiting time from referral to assessment in 2010/11 was six days, excluding the area affected by the system upgrade. Fraser Health could not provide the number of people awaiting an assessment as of March 31, 2011, but told us that in 2010/11 25 per cent of people were assessed within two weeks of referral and that the average wait was 21 days. Vancouver Coastal Health was unable to provide this information, but it had recently begun tracking how often clients are seen within priority time frames attached to their referrals, for example 24 or 48 hours. VIHA could not report the number of people awaiting an assessment as of March 31, 2011, but did report that the average waiting time for an assessment in 2010/11 was 68 days.

Delays in assessment are a serious concern because seniors generally cannot receive subsidized services until their regional health authority has assessed them as eligible and in need of assistance. It is also important that reliable information about waiting times for assessments is collected and tracked because only then will the health authorities and the ministry be in a position to measure their performance in this area.

The Ministry of Health has taken some steps to address the gap in data it receives by issuing a directive to the health authorities requiring them to provide the ministry with the percentage of seniors whose assessments had been completed within 14 days of referral.⁶³

The directive required the health authorities to report the completed assessments data to the ministry every quarter beginning in July 2009. This deadline was missed, but the health authorities did begin submitting information to the ministry in September 2009. However, the ministry's initial review of this data revealed problems that it felt made some of the information unreliable. As of October 2011, the ministry was not yet able to provide us with what it considered to be reliable information. As a result, the ministry was not able to comment on the actual length of waiting times for assessments in the province.

When these data collection issues are fully resolved, the ministry should be able to calculate the percentage of clients whose assessments were completed within 14 days of referral. Once this has been done, the ministry can identify any health authorities with waiting times substantially longer than this and work with them to

⁶³ Ministry of Health directive, February 2009.

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develop methods for eliminating those backlogs. It would also be useful for seniors and their families to be able on an ongoing basis to access current information about waiting times for assessments in their region, but the ministry has not made a commitment to make this information publicly available.

The Ombudsperson finds that

- F6. The health authorities are not ensuring that all seniors are assessed for home and community care services within two weeks of referral as set out in Ministry of Health policy.

The Ombudsperson recommends that

- R7. The health authorities ensure that seniors are assessed for home and community care services within two weeks of referral.

The Ombudsperson finds that

- F7. The Interior Health Authority and the Vancouver Coastal Health Authority do not track the length of time seniors wait to be assessed for home and community care services.

The Ombudsperson recommends that

- R8. The Interior Health Authority and the Vancouver Coastal Health Authority track the length of time seniors wait to be assessed for home and community care services.

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Percentage of Seniors Assessed

We learned from the health authorities and the Ministry of Health that approximately 70 per cent of seniors over 80 in British Columbia have never been assessed for home and community care services. While many of these seniors may be in good health, others may have care needs that could qualify for assistance and support.

In Denmark, under the *Preventive Home Visits to the Ageing Law* of July 1996, government agencies must proactively offer home visits once each year to all seniors over 75 in order to inform them of available services and identify those who may require support.⁶⁴ While the percentage of seniors receiving home support in Denmark in recent years has increased, overall health spending on seniors over 80 has decreased. This reduction appears to be the result of funds being diverted from institutional care to a more cost-effective home support program.

If the ministry and the health authorities established a similar program to ensure that seniors and their families are aware that they can request an assessment for home and community care services, this would support the ministry's stated goal of helping seniors live safely and independently in their own homes for as long as possible.

Percentage of Older Seniors Assessed

According to the Ministry of Health, approximately 70 per cent of seniors in British Columbia over the age of 80 have not been assessed to determine if they need or could benefit from home and community care services.

Source: Ministry of Health, letter to the Office of the Ombudsperson, June 23, 2009.

The Ombudsperson finds that

- F8. The Ministry of Health and the health authorities do not have an adequate program in place to ensure that seniors and their families are informed of the availability of home and community care services and the opportunity to have their eligibility for subsidized services assessed.

The Ombudsperson recommends that

- R9. The Ministry of Health work with the health authorities and other stakeholders to develop a program to ensure that:
- all seniors and their families are informed of the availability of home and community care services
 - all seniors and their families are informed that they can meet with health authority staff to determine what supports are available to them

⁶⁴ T. Rostgaard, SFI — The Danish National Centre for Social Research, "Danish Elder Care: Home Help and the Approach of Preventive Interventions," presented February 22-23, 2011, 10. 2011 Health Policy Conference, Vancouver, B.C. <<http://www.chspr.ubc.ca/files/conference/2011/Slides/TineRostgaardBoomerangstfolder.pdf>>.

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Information about Assessments Provided to Clients

A number of people complained to us that their health authority had refused to give them a copy of their own home and community care assessment and told them that in order to get it, they would have to make a request under the *Freedom of Information and Protection of Privacy Act (FOIPPA)*.

In the course of investigating these complaints, we confirmed that the Interior, Fraser, Vancouver Island and Vancouver Coastal health authorities require people to use the *FOIPPA* process to access their own assessment information. In addition, Northern Health reported that it does not routinely provide seniors with copies of their home and community care assessments because the assessments are difficult to understand. However, Northern Health stated that it believes an assessment is the seniors' information, and that a case manager would explain an assessment to a senior and his or her family if requested to do so. Bill's story is one example of the complaints we heard about this issue. (The name below has been changed to protect confidentiality.)

Bill's Story

Bill had been receiving subsidized home support services from the Interior Health Authority for several years before he became ill and had surgery. Following his surgery, Interior Health reassessed him and decided to reduce his home support hours. Bill asked the health authority for a copy of his reassessment but was told that he would have to request a copy of it under the Freedom of Information and Protection of Privacy Act (FOIPPA). Under that legislation, Interior Health had up to 30 days to respond to his request. Bill felt this was unfair and unreasonable, so he complained to our office.

When we investigated Bill's complaint, Interior Health confirmed that its usual practice was to tell people who asked for a copy of their assessment to submit a written request, which it would then process under FOIPPA. We raised this question with the then-CEO of Interior Health who was surprised to learn that the health authority did not provide seniors with copies of their assessment documents when requested to do so. After some consultation with our office about the fairness of this practice, the Interior Health Authority agreed to provide Bill with a copy of his assessment.

It should be noted that the *FOIPPA* does not require that information be released to the public only in response to a formal request made under the Act. To the contrary, the *FOIPPA* allows government bodies to designate records that can be routinely released without a formal request under the Act. The government has identified the following benefits to the routine release of records. Routine release:

- is efficient and effective in meeting the needs of the public
- decreases the administrative burden of the *FOIPPA* and saves government time and money
- reduces workload and costs by reducing the number of freedom of information requests that must be processed⁶⁵

The *FOIPPA* is also not intended to replace other procedures for accessing information.⁶⁶ Because seniors have a right to understand the information on which decisions about their care is based the health authorities should offer to provide them with copies of their home and community care assessments.

⁶⁵ Ministry of Labour, Citizens' Services and Open Government, *Guidelines for the Routine Release of Records Information*, October 1997 <http://www.cio.gov.bc.ca/cio/priv_leg/foippa/guides_forms/rr_guide.page>.

⁶⁶ *Freedom of Information and Protection of Privacy Act*, R.S.B.C. 1996, c. 165, s. 2(2).

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The Ombudsperson finds that

- F9. It is unreasonable for the Fraser Health Authority, Interior Health Authority, Vancouver Island Health Authority, and Vancouver Coastal Health Authority to require seniors to submit a freedom of information request in order to obtain a copy of their own home and community care assessment and it is unreasonable for Northern Health Authority to not provide seniors a copy of a requested assessment.

The Ombudsperson recommends that

- R10. The health authorities offer seniors copies of their home and community care assessments. In any case where health authorities believe that providing the complete assessment would harm a senior's health, they should provide an edited copy.

Fees and Fee Waivers

After a health authority decides that a senior is eligible for subsidized service, its staff calculate how much the senior will have to pay to receive the home support, assisted living or residential care services the health authority has identified the senior needs. Health authorities usually refer to the amount paid by seniors as the “co-payment” or a fee for services. It may also be called a user fee. As discussed under “Federal Legislation” in the Background section, home and community care services are excluded from the definition of “insured health services” in the *Canada Health Act*. This means that there can be charges imposed for some of the services provided.

Each year, the Ministry of Health uses information obtained from the Canada Revenue Agency to verify the previous year's income of each senior who receives subsidized home and community care services. The ministry does this in order to determine what each person's fees should be for the next year, as these fees are tied to income. Every fall, health authorities send written notices to seniors informing them what their costs will be for the next year. For example, in September 2009, the ministry used 2008 income data to set the fees that were to take effect in January 2010. This delay between when income is assessed and when rates take effect can result in rates that do not reflect a senior's actual financial circumstances at the time he or she begins paying a new rate. People who experience a significant change in their financial circumstances can ask the health authority to reassess their rate.⁶⁷

If a senior or the senior's spouse experiences financial difficulty as a result of an assessed fee, they can apply for a temporary reduction or waiver. The *Hospital Insurance Act Regulations* and the *Continuing Care Fees Regulation* allow health authorities, who have been delegated this power by the Minister of Health, to waive all or a portion of home and community care fees in cases of hardship.⁶⁸ When seniors request such a waiver or reduction, health authority staff fill out a form (called an Application for Temporary Reduction of Client Rate) and perform calculations using the joint income of the senior and the senior's spouse. The ministry's

⁶⁷ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Rates: Changes in Client Rates, 7.B.3, 1.

⁶⁸ *Hospital Insurance Act Regulation*, B.C. Reg. 25/61, s. 8.6; *Continuing Care Fees Regulation*, B.C. Reg. 330/9, s. 6.

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policy states that “health authorities are expected to process a client’s application for temporary reduction of client rate in a timely and responsive manner” and notify applicants in writing of their decisions.⁶⁹

People whose financial hardship lasts longer than one year must re-establish their eligibility for a waiver each year. This is done by submitting a new application one month before the previously approved waiver expires. Seniors who are benefitting from a waiver and whose financial circumstances change must notify their health authority within 10 days so that their ongoing eligibility for a fee reduction can be verified.⁷⁰

While it is possible for people who are experiencing serious financial hardship to request a temporary reduction to their home and community care fees, not everyone is aware of this option. We received complaints from seniors who said that even after they expressed concern during the application process about their ability to pay, health authority staff did not tell them they could ask to have their fees reduced or waived. Information submitted to our office indicates that in the absence of a specific request, this option is not consistently explained. The most convenient and comprehensive way to inform people of this option would be to include detailed information about it in any letter or mailing about user fees that is sent to subsidized seniors.

We asked the health authorities how many fee reduction applications they received in 2008/09 and 2009/10 from home support, assisted living and residential care seniors and how many they approved.

The Interior Health Authority told us that it doesn’t track the number of applications it receives. However, since February 2010, it has tracked the number of approvals by program area. As of July 2010, Interior Health had approved a total of 105 fee reductions. Forty-eight of these were approved for residential care. This involves less than 1 per cent of its total number of subsidized residential care beds. The Interior Health Authority approved 16 fee reductions for assisted living during the same time period (about 2 per cent of its 948 subsidized units). Interior Health also approved 41 fee reductions for home support services (about 1 per cent of the number of clients who received subsidized home support in Interior Health in 2009/2010).⁷¹

The Fraser Health Authority has the most accurate information tracking. It provided the information in the table below. Fraser Health tracks the number of fee reduction applications it received and the number approved for residential care and assisted living but only the number of applications approved for home support.

The Ministry of Health’s Definition of Hardship

According to Ministry of Health policy, a senior experiences “serious financial hardship” if paying the “client rate” means that the senior or the senior’s spouse is unable to pay for shelter, food, heating, prescribed medication or other prescribed health care services.

Source: Ministry of Health, *Home and Community Care Policy Manual*, April 2011, 7.D., 1.

⁶⁹ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Rates: Temporary Reduction of Client Rates, 7.D, 1.

⁷⁰ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Rates: Temporary Reduction of Client Rates, 7.D.

⁷¹ The number of clients receiving subsidized long-term home support services was provided by Ministry of Health staff, who told us that because of incomplete data submissions from the IHA in 2008/09 and 2009/10, some measures might be understated. Therefore, it is possible that the 41 temporary fee reductions for home support services may be less than 1 per cent of those who received subsidized home support in 2009/10 in the IHA.

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Table 1 – Residential Care and Assisted Living Hardship Applications, Fraser Health, 2008/09 and 2009/10

FEE REDUCTION REQUESTS	2008/09	2009/10	Total
Received from residential care clients	44	59	103
Approved	43	55	98
Denied	1	4	5
Received from assisted living clients	6	5	11
Approved	5	5	10
Denied	1	0	1

The table above shows that in 2008/09 and 2009/10, Fraser Health approved 95 per cent of the applications it received for reductions to residential care fees, and 91 per cent of applications it received for reductions to assisted living fees. In Fraser Health, the vast majority of people who applied for a fee reduction for assisted living or residential care had their fee reduced or waived. The actual number of people who applied for reductions was low, however — less than 1 per cent of those receiving subsidized residential or assisted living care in Fraser Health. In the same period, Fraser Health approved 123 fee reductions for home support clients in 2008/09 and 75 fee reductions for home support clients in 2009/10.⁷² Again, this is about 1 per cent of those who received subsidized home support in 2009/2010 in Fraser Health.

The Northern Health Authority, the Vancouver Coastal Health Authority and the Vancouver Island Health Authority do not track this information and so were unable to respond to our request.⁷³ If each health authority tracked the number of fee reduction applications received and the number granted and denied by program area, the information could assist the ministry when it is considering adjustments to rates for home and community care services.

Equally important is making decisions on applications for fee reductions in a timely manner. For example, in early 2010, the ministry directed the health authorities to begin charging a daily fee of up to \$29.40 to people receiving convalescent care. This type of care is temporary and is commonly referred to as “short-term residential care.” It is often required after discharge from an acute care hospital, so those receiving convalescent care will normally continue to have their own shelter costs, which may include mortgage or rent payments. This means that having to pay convalescent care fees can quickly cause serious hardship and so the opportunity to apply for a reduction is important. Since convalescent care is temporary care, it is critical that seniors who are experiencing financial hardship find out that they can apply for a fee reduction and also that these applications be considered as quickly as possible.

⁷² The Fraser Health Authority does not track the number of fee reduction applications it receives for home support. It tracks only the number of applications approved.

⁷³ In November 2011, VIHA advised us that it had begun tracking fee reduction requests for residential care and assisted living.

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The Ombudsperson finds that

- F10. The Ministry of Health and the health authorities do not consistently provide seniors receiving subsidized care with clear information about the availability of fee reductions or waivers.

The Ombudsperson recommends that

- R11. The Ministry of Health and the health authorities include information about how to apply for fee reductions and waivers when they mail fee notices to clients who receive subsidized home and community care services, and look for other opportunities to make this information accessible in a timely manner to those who need it.

The Ombudsperson finds that

- F11. The health authorities are not consistently tracking the number of fee reduction applications they receive, approve and deny.

The Ombudsperson recommends that

- R12. The health authorities track the number of fee reduction applications they receive, approve and deny, and report this information to the Ministry of Health to assist the ministry in evaluating the capacity of seniors to pay home and community care fees.

The Ombudsperson finds that

- F12. The Ministry of Health has not established a time limit within which health authorities must respond to fee reduction applications.

The Ombudsperson recommends that

- R13. The Ministry of Health establish a reasonable time limit within which health authorities must decide and respond in writing to fee reduction applications.

Sponsored Immigrants

A significant issue that we looked into during the course of this investigation was about the eligibility of sponsored immigrants for home and community care services and the fees they are charged. As with most other seniors' care issues, health authorities make the day-to-day decisions about the eligibility and rates in this area, but are guided in these tasks by provincial legislation and the overarching policies set by the Ministry of Health. While this issue has recently been largely resolved, it usefully illustrates some of the challenges that can face newer members of our B.C. communities and the importance of ensuring that they are treated in a fair and equitable manner.

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Sponsored immigrants are people who have been sponsored by a close relative to immigrate to Canada. Between 2005 and 2009, 5,733 new immigrants who were 65 and older came to British Columbia; 86 per cent of these were sponsored by their families.⁷⁴ The immigration process begins when a family member applies to the federal government to sponsor a relative to come to Canada. If this application is successful, the sponsored immigrant achieves permanent resident status (formerly called landed immigrant status). Achieving permanent resident status requires the immigrant's relative to sign a financial support agreement known as an "undertaking."

An undertaking begins on the date that the sponsored person becomes a permanent resident and can last anywhere from three to ten years, depending on the sponsor's relationship to the immigrant and the age of the immigrant when he or she becomes a permanent resident. The sponsorship period is three years for a spouse and ten years for a parent.⁷⁵ Undertakings require sponsors to "provide for the basic requirements" of sponsored persons and any relatives who accompany them to Canada, if they are not self-supporting during the period of the undertaking.⁷⁶ The sponsor must provide food, clothing, shelter, fuel, utilities and household supplies, as well as pay for any health needs that are not covered by basic public health care. The agreement also states that if the government makes a payment for a requirement or service that the sponsor has promised to provide, the sponsor will be considered in default and the government can recover these amounts from the sponsor.⁷⁷ A sponsor's financial obligations continue, even if the immigrant becomes a citizen during the period of the undertaking.

Sonya's story is an example of the types of concerns we heard about the eligibility and cost issues that arose for sponsored immigrants seeking home and community care services. (The name below has been changed to protect confidentiality.)

Sonya's Story

Sonya wanted to sponsor her father to come to Canada so she signed an undertaking in which she agreed to be responsible for him for 10 years. He came in 2001 and became a Canadian citizen in 2005. In 2007, he developed Alzheimer disease and required residential care. When he was admitted to a facility, Sonya learned that he would be charged the highest daily rate, which at the time was approximately \$71 per day. Sonya thought that residential

Excerpt from the Ministry of Health Services' Draft Sponsorship Manual

"This policy is based on the understanding that the Undertaking of Assistance is intended to prohibit the use of Canada's various assistance programs by sponsored immigrants throughout the sponsorship period. It is the sponsor's responsibility to make use of family resources to ensure that sponsored family members are provided with adequate care whether by their own personal input or by the purchase of needed services."

Source: Ministry of Health and Ministry Responsible for Seniors, *Sponsorship Manual, Draft #6*, March 1997, 3.

⁷⁴ Ministry of Regional Economic and Skills Development, *Immigrant Seniors in British Columbia*, December 2010 <<http://www.welcomebc.ca/local/wbc/docs/communities/fact-seniors-2010.pdf>>.

⁷⁵ *Immigration and Refugee Protection Regulations*, SOR/2002-227, s. 132(1).

⁷⁶ *Immigration and Refugee Protection Regulations*, SOR/2002-227, s. 132(4)(a).

⁷⁷ Citizenship and Immigration Canada, *Application to Sponsor, Sponsorship Agreement and Undertaking*, July 2011, 5.

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care rates were supposed to be calculated based on after-tax income and didn't understand why this process was not being applied to her father. Based on his after-tax income, she believed that he qualified to pay the minimum rate, which was approximately \$23 per day.

When Sonya brought these concerns to her health authority, staff there explained that sponsored immigrants were charged the highest subsidized rate. Health authority staff also told Sonya that her father was not eligible for a hardship waiver since both her and her father's income were included in the calculations, and this amount was too high to qualify. Sonya was concerned that although her father required residential care on medical grounds, he was being treated differently from other people with similar needs. She decided to contact the Ministry of Health with her concerns. The ministry responded to Sonya by referring her back to the health authority.

Accordingly, although Sonya and her father believed they were required to pay more than triple the daily rate that they should have paid, they were not allowed to apply for a reduction. The available complaints processes did not result in any satisfactory solution. Sonya's story illustrates the hardship and confusion that can potentially be caused by the imposition of fees without clear legislative authority.

Eligibility Policy

Between August 2008 (the beginning of our investigation) and April 2011, the ministry's policy manual stated that a person must meet all of the following criteria in order to be eligible for subsidized home and community care services:⁷⁸

- be at least 19 years old
- be a Canadian citizen or permanent resident or hold a Minister's Permit granted by the Minister of Employment and Immigration
- have lived in British Columbia for 12 consecutive months immediately before making an application for personal- or intermediate-level care
- have lived continuously in British Columbia for a waiting period ending at midnight on the last day of the second month following the month in which residency began to be eligible for extended care
- be unable to function independently because of chronic, health-related problems that do not require care in an acute or rehabilitation program⁷⁹

Although according to these criteria, all permanent residents were eligible for subsidized home and community care, the previous version of the *Home and Community Care Policy Manual* also stated that permanent residents who were sponsored immigrants were not eligible during the period covered by their undertaking, except under two conditions.⁸⁰ If one of the following conditions did not apply, the sponsored immigrant would have to pay the full unsubsidized rate.

⁷⁸ The Ministry of Health's revised *Home and Community Care Policy Manual* took effect on April 1, 2011.

⁷⁹ Ministry of Health, *Home and Community Care Policy Manual*, March 1992, Client Access: Eligibility, 2.A, 1-2.

⁸⁰ Ministry of Health, *Home and Community Care Policy Manual*, March 1992, Client Access: Eligibility, 2.A, 1-2.

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The first condition was if the sponsor was found to be unable to meet financial obligations. However, the manual did not specify why or when a sponsor would be considered unable to do so, who could make that decision or how the decision could be challenged. When the health authority determined that this condition applied, a client rate for services would then be assessed based on the total household income of the sponsor, the sponsor's spouse and the sponsored immigrant and spouse.⁸¹

The second condition was if a sponsored immigrant was assessed as being in need of “extended care” services. Extended care is the old name for a category of care that has been more recently called “high care need intensity.” Between March 1992 and April 2011, the ministry's policy manual stated that the restrictions on the eligibility of sponsored immigrants did not apply to extended care services.

In September 2009, the ministry explained to us that its policy meant that any sponsored immigrant who was assessed as needing an equivalent level of care to “extended care” (high care need intensity) was considered eligible for subsidized home and community care services, but had to pay the maximum rate, as was the case for Sonya's father. This policy was in effect until April 1, 2011 when the revised version of the ministry's policy manual replaced it.

Until April 1, 2011, the health authorities also used a draft sponsorship manual, first developed by the ministry in 1997, to guide their decisions about eligibility and rates for sponsored immigrants. Although its stated purpose was to assist case managers to implement the ministry's policy on sponsored immigrants, the draft manual was never finalized or formally adopted by the ministry. Despite the fact that it was never formally adopted, it was used by case managers because it provided more detailed guidance than the ministry's policy manual. The draft manual set out the conditions under which a sponsor could be considered financially unable to provide support. These conditions were:

- the sponsor had died and made no provision for support
- the sponsor had been incarcerated, institutionalized or could not be found and had made no provision for support
- the sponsor was no longer willing to fulfill his or her responsibility
- the income of the sponsored immigrant, the sponsor and the sponsor's spouse was such that the sponsor was not able to provide adequate care without assistance.⁸²

The draft sponsorship manual also stated that a sponsored immigrant who was assessed as requiring care at an extended care level did not require a waiver in order to receive services, but would then be assessed the maximum rate if the sponsored immigrant required care in a residential facility.⁸³

Current Status

Since many seniors in British Columbia who require home support, assisted living or residential care cannot afford to pay the full cost of those services themselves, they apply through their regional health authority to receive subsidized care. If successful, the rates they are then charged are based on their after-tax income. Until the introduction of the revised *Home and Community Care Policy Manual* on April 1, 2011, this was not the case for eligible sponsored immigrants who, depending on their circumstances, were told either that

⁸¹ Ministry of Health, *Home and Community Care Policy Manual*, November 1998, Financial Management: Client Rates, 8.L, 12.

⁸² Ministry of Health and Ministry Responsible for Seniors, *Sponsorship Manual*, Draft #6, March 1997, 5-8.

⁸³ Ministry of Health and Ministry Responsible for Seniors, *Sponsorship Manual*, Draft #6, March 1997, 9.

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they had to pay the maximum rate for these services or that their rate would be calculated using not only their own household income, but that of their sponsor and their sponsor's spouse. These practices were not supported by the legislation that was in effect at that time and which remains currently in force.

The *Continuing Care Act* and the *Continuing Care Fees Regulation* set the rules for the rates that can be charged for the range of services referred to as "continuing care." Section 6(2) of the *Continuing Care Act* permits operators to charge clients amounts in excess of the rate prescribed by regulation only when the Minister of Health has directed this, or when permitted in an agreement made with the operator.⁸⁴

Although health authorities were charging sponsored immigrants rates in excess of the rate prescribed, the Minister of Health had not issued any directives authorizing operators to do so. The ministry has confirmed that the previous *Home and Community Care Policy Manual* and the draft sponsorship manual were not considered directives made under section 4(4) of the *Continuing Care Act*. As well, under section 6(3) of the Act, cabinet also has the power to make regulations that set different rates for different classes of home and community care clients. It has never done so for sponsored immigrants.

However, despite this the ministry's previous *Home and Community Care Policy Manual* set out a specific and separate process for determining the rates charged to sponsored immigrants when it was determined that the sponsor was unable to fulfill his or her obligations.

Progress

Our office raised this issue with the Ministry of Health during the course of our investigation. Subsequently, the ministry changed its eligibility policy to eliminate the distinction between sponsored immigrants and other permanent residents and citizens. This change is reflected in the revised *Home and Community Care Policy Manual*.

While this change is welcome, the fact remains that between March 1997 and April 1, 2011, the policies and practices of the Ministry of Health and the health authorities regarding sponsored immigrants were not based on a legislative foundation.⁸⁵ Ministry practice in this area was unfair for the following reasons:

- The previous *Home and Community Care Policy Manual* directed health authorities to charge sponsored immigrants, who had met certain conditions, a rate that was based on their household income combined with the household income of their sponsor. This policy was not authorized by legislation.
- The ministry's draft sponsorship manual directed health authorities to charge eligible sponsored immigrants the maximum rate for home and community care services. This practice had no basis in legislation and appeared to contradict the ministry's own *Home and Community Care Policy Manual*.

⁸⁴ Section 4 of the Act indicates that the minister may enter into a written agreement with an operator under which the government will make payments on behalf of clients who receive continuing care. An agreement may specify terms and conditions that the operator must comply with in addition to standards, guidelines or directives issued under subsection (4). *Continuing Care Act*, R.S.B.C. 1996, c. 70, ss. 6(2) and 4.

⁸⁵ While we were unable to pinpoint the date that the ministry's practice on sponsored immigrants began, it was clearly communicated to assessors as of March 1997, which was the date of the draft sponsorship manual provided to us in September 2009 by the ministry.

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- It was unreasonable and contradictory to charge the maximum rate for home and community care services to sponsored immigrants who had been deemed eligible for those services in the first place because their sponsors were considered unable to meet their financial obligations. Immigrants who have been sponsored by people no longer able to meet their sponsorship obligations are unlikely to be able to afford the maximum rate.

These practices were not only unfair in principle, but they also increased the likelihood that sponsored immigrants would be unable to access the care they needed and were entitled to receive. The ministry has now corrected the situation by eliminating the distinction between sponsored immigrants and other permanent residents and citizens when it comes to eligibility and rates charged for home and community care services. While this is a very positive step, many sponsored immigrants will have already felt the financial consequences of the ministry's former policy.

The Ombudsperson finds that

- F13. The Ministry of Health did not have authority to use a separate and distinct process to determine the rates that sponsored immigrants had to pay for home and community care services between March 31, 1997, and April 1, 2011.

The Ombudsperson recommends that

- R14. The Ministry of Health establish a process that permits any sponsored immigrants charged home and community care fees between March 31, 1997, and April 1, 2011, to apply to the ministry for a review of the fees paid and, where appropriate, a reimbursement for excess fees paid.

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Complaints

People who want to complain about home and community care services are faced with a confusing array of choices about how to proceed. Bringing concerns or problems to the attention of the staff who provided the service is usually the first step, and may result in a quick resolution without the need to involve senior staff. However, there are times when discussing a complaint with front-line staff is not possible, appropriate or sufficient. In other cases, people are uncomfortable doing this because it means confronting the person who is the source of the concern. Seniors (and their families) can be understandably reluctant to confront those they depend on to provide care. In some cases, people may feel that their complaint is too serious to be handled in this informal way.

If the complaint involves someone who receives subsidized home and community care services, taking it to that person's case manager at the regional health authority is usually the next step.

Another option is to complain to the regional patient care quality office (PCQO). If not satisfied with the PCQO's response, a person may pursue the complaint by taking it to the regional patient care quality review board (PCQRB). Both of these options became available in October 2008, when the provincial government brought in a new piece of legislation called the *Patient Care Quality Review Board Act*.

This section of our report discusses the importance of advocacy in helping seniors raise their concerns and looks at how existing complaint processes work. There is further discussion of program-specific complaint issues in the Home Support, Assisted Living, and Residential Care sections of this report.

Anonymous Reporting of Complaints about Vancouver Island Health Authority Services

The Vancouver Island Health Authority (VIHA) has issued a request for proposals (RFP) for a confidential reporting service that will allow people to submit complaints through a confidential website operated by a third-party provider. The RFP indicates that the no-cost service will be accessible to the public, all VIHA employees, physicians and volunteers who wish to report perceived wrongdoing. VIHA expects that a person who wants to complain would be able to access this confidential website from a link on the VIHA website. The third-party provider will look at the information and decide where to direct the complaint within VIHA for follow up. VIHA expects the website to be operational by the end of 2011.

Patient Care Quality Offices and Review Boards

Patient care quality offices and review boards were created in 2008 by the enactment of the *Patient Care Quality Review Board Act*. Under this Act, each health authority must establish a patient care quality office (PCQO) to receive and process complaints about care quality in its jurisdiction.⁸⁶ A care quality complaint is defined in the Act as a complaint about the delivery of, or the failure to deliver, health care or a related service, or about the quality of health care or a related service.⁸⁷

⁸⁶ *Patient Care Quality Review Board Act*, S.B.C. 2008, c. 35, s. 2.

⁸⁷ *Patient Care Quality Review Board Act*, S.B.C. 2008, c. 35, s. 1.

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Although the definition of “health care” in the Act is broad, according to the Ministry of Health’s *Patient Care Quality Review Boards Orientation Manual*, the PCQRBs will not consider complaints related to:

- health professionals providing services in private practice, where the services are funded by the Medical Services Plan (MSP) or PharmaCare
- health care or services that are paid for entirely by the patient or a private insurer⁸⁸
- health care or services provided in privately funded surgical centres, unless provided under contract with a health authority
- health care or services provided by HealthLink BC, such as nurse line, where the services are funded by the ministry
- assisted living services that are not provided by a health authority
- involuntary admissions under the *Mental Health Act*
- decisions of the Mental Health Review Board related to involuntary admissions
- an action or decision of a medical health officer or delegate under the *Community Care and Assisted Living Act (CCALA)* and its regulations
- a decision of the Community Care and Assisted Living Appeal Board.⁸⁹

These additional restrictions in the manual raise a concern that some complaints might be dealt with by a PCQO and not by a PCQRB.

Under the Act, complaints to a patient care quality office must be submitted by a person who received the care in question, or someone acting on his or her behalf. Complaints cannot be submitted anonymously. The limitation on who can submit a complaint to a PCQO prevents some individuals and groups from accessing this process. The ministry informed our office that in addition to responding to care quality complaints, the PCQOs can “respond to a broader range of inquiries and complaints,” including responding to complaints from family councils who wish to raise a general care quality issue about a facility. The Act, however, has not been changed to reflect this understanding of the ministry. If the ministry intends for PCQOs to be able to respond to a broader range of complaints, including from a broader range of people, such as family councils, this change needs to be clarified through amendments to the legislation.

The Ombudsperson finds that

- F14. The patient care quality offices (PCQOs) are only able to process care quality complaints that are made by or on behalf of a particular person who received care and this prevents them from responding to broader care quality issues.

The Ombudsperson recommends that

- R15. The Ministry of Health take the steps necessary to ensure that PCQOs can respond to a broader range of complaints, including complaints from resident and family councils.

⁸⁸ With the exception of private pay residential care services in facilities licensed under the *CCALA* and the *Hospital Act*.

⁸⁹ Ministry of Health, *Patient Care Quality Review Boards Orientation Manual*, August 2011, 16.

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Role of Patient Care Quality Offices and Review Boards in Processing Complaints

Once PCQO staff have verified that a complaint is within their jurisdiction, the role of the PCQO is to “process the care quality complaint in accordance with any directions provided by the minister under section 6...”.⁹⁰ There is no requirement that a complaint be investigated. The Act outlines what PCQO staff may but are not required to do when processing a complaint. The only information and records that the PCQO may access are ones that are available to the health authority, or that have been provided by a contracted agency or the person making the complaint. In addition, PCQO staff may consider all the circumstances related to the complaint and make decisions about which agencies or organizations are involved and the policies and procedures that apply to the complaint.⁹¹

After a complaint has been processed, the patient care quality office must report to the complainant whether the complaint was resolved. According to the Ministry of Health, the PCQOs communicate the results back to complainants even if they do not constitute a resolution. This information must include a description of the office’s understanding of the circumstances, a description of the applicable policies and procedures and any actions taken to resolve the complaint.⁹²

The ministerial directive issued under section 6(1)(d) of the *Patient Care Quality Review Board Act* establishes the following additional requirements for responding to complaints. Patient care quality offices, in responding to a complaint:

- inform the complainant that the complaint has been received and outline the next steps in the complaints process within two business days
- determine, as soon as possible, whether the complaint is within the jurisdiction of the office and inform the complainant immediately
- record the steps of the investigation or the process for complaints within the PCQO’s jurisdiction, including relevant documents that are part of the process, and engage the complainant and other affected parties as required
- complete the complaints process within 30 business days, or within a time frame that is agreed to by the complainant and the PCQO
- keep the complainant updated on the progress of the complaints process no less than once every 20 business days, for complaints where an extension is agreed to, or where the complaint relates to a licensed facility under the *Community Care and Assisted Living Act* and requires additional time to resolve
- provide updates verbally or in writing and document them
- inform the complainant of the results of the process⁹³

⁹⁰ *Patient Care Quality Review Board Act*, S.B.C. 2008, c. 35, s. 4(2)(a).

⁹¹ *Patient Care Quality Review Board Act*, S.B.C. 2008, c. 35, s. 7(1)(a) and (b).

⁹² *Patient Care Quality Review Board Act*, S.B.C. 2008, c. 35, s. 7(1)(c).

⁹³ Ministry of Health ministerial directive under section 6(1)(d) of the *Patient Care Quality Review Board Act*, undated.

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The minister's directive also requires that patient care quality offices "record the steps of the investigation or complaints process, including relevant documents that are part of the process, and engage the complainant and other affected parties as required."⁹⁴ While the minister's directive establishes processes for the patient care quality offices in responding to complaints, it is not available to the public on the health authority websites.

The Act's use of the word "process" rather than "investigate" in describing how PCQOs are to respond to complaints is significant. A body that conducts an investigation is charged with inquiring into and examining the circumstances surrounding a complaint and then drawing its own conclusions on the basis of the information gathered. In contrast, a body that only processes a complaint may not have a clear, active role in the inquiry process and may rely on the conclusions of another part of the organization or another agency. In the course of our investigation, we found that patient care quality offices typically refer the investigation aspect of the process to another part of the organization, such as the health authority licensing offices, and then report the results to the complainant.

We reviewed how the ministry and the health authorities describe the role of the patient care quality offices. We noted inconsistencies between the description of the PCQOs' role in the Act and how this role is described in the minister's directive and by the offices themselves. For example, the minister's directive refers to an investigation or complaint management process, and some of the letters from the PCQOs to complainants and to our office describe their process as an "investigation." In addition to contributing to inaccurate public perceptions about what the PCQOs actually do, this indicates a lack of clear direction on how they are expected to respond to complaints.

A person who is not satisfied with how a patient care quality office has handled his or her complaint has the option of taking that complaint to the regional patient care quality review board (PCQRB). As with PCQOs, there is a separate PCQRB for each health authority. The PCQRBs differ from the PCQOs in that they are accountable directly to the Minister of Health and operate independently of the health authorities. Each board consists of four to six members, including a chair, and are appointed by the Minister of Health.

The powers and duties of the review boards are set out in the Act. Complainants or those acting on their behalf can contact the review board to request a review of a complaint, either in writing or by telephone.⁹⁵ In addition, the minister may direct a review board to review a complaint, whether or not a care quality complaint has been submitted to a PCQO on that issue. In such a case, the review board must advise the minister when it has processed the complaint and report whether the complaint was resolved. The review board must also report to the minister on specific matters as requested, and may include recommendations to the minister and the health authority for improving patient care quality or the patient care quality complaints process.⁹⁶ Unless directed by the minister, a PCQRB considers a complaint only if it has first been addressed by the health authority's PCQO. The review board then determines whether the complaint is within its jurisdiction.

⁹⁴ Ministry of Health ministerial directive under section 6(1)(d) of the *Patient Care Quality Review Board Act*, undated.

⁹⁵ *Patient Care Quality Review Board Act*, S.B.C. 2008, c. 35, s. 13(1).

⁹⁶ *Patient Care Quality Review Board Act*, S.B.C. 2008, c. 35, ss. 13(1), 14 (c)(i) and 15(2).

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Once a PCQRB decides that a complaint is within its jurisdiction, it must review the complaint “in accordance with any directions provided by the minister.”⁹⁷ The minister has issued a directive that sets out:

- the method for receiving review requests
- the method for processing review requests
- the circumstances in which a complainant’s consent is required
- the information boards should record
- the accessibility of information⁹⁸
- the reporting of information to complainants and to the minister

The directive also contains specific timelines for certain stages of the review process.

In conducting a review, a board may consult with and request additional information or records from the health authority or any of its contracted agencies, consider any information and records from the health authority, contracted agencies or the complainant, and consider all of the circumstances and the applicable policies and procedures. At the end of the review, the PCQRB must report to the complainant that the review has been completed and state whether the complaint was resolved. The report must include a summary of the circumstances of the complaint as understood by the PCQRB, the applicable policies and procedures, and any actions taken to resolve the complaint.⁹⁹ The report must also include the rationale for any findings and recommendations that the review board has made in response to the complaint.¹⁰⁰

The patient care quality review boards “would be more likely to make recommendations regarding policy and process improvement rather than recommend compensation at the individual level.”

Source: Ministry of Health letter to the Office of the Ombudsperson, June 2009.

One of the roles of the PCQRBs is to make recommendations to the health authorities and the ministry. These recommendations can be aimed at improving the process used to submit and address complaints, improving the quality of patient care, resolving a specific care quality complaint, or addressing any other matter that has arisen in a review.¹⁰¹ The types of recommendations that may be made at the conclusion of a review can include:

- that a PCQO reconsider a complaint, taking into account any recommendations that a review board deems appropriate to achieve resolution
- that service delivery and quality of care be improved

⁹⁷ *Patient Care Quality Review Board Act*, S.B.C. 2008, c.35, s. 13(3).

⁹⁸ Accessible information may include: whether the complaint is jurisdictional; what the nature of the complaint was; what action, if any, the health authority took; why the complainant was not satisfied with the PCQO process and what outcome was sought; what policies and procedures were applicable; and what were the relevant review board recommendations regarding the complaint and the health authority’s response.

⁹⁹ *Patient Care Quality Review Board Act*, S.B.C. 2008, c. 35, ss. 13(4) and 14.

¹⁰⁰ Ministry of Health, *Patient Care Quality Review Boards Orientation Manual*, October 2008, 30.

¹⁰¹ Patient Care Quality Review Boards, *Annual Report*, 2009/10, 4.

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- that educational initiatives be undertaken
- that an apology be offered
- that mediation be sought¹⁰²

In some cases, PCQRBs may recommend improvements to the complaints process in a patient care quality office.¹⁰³ These recommendations address issues such as responding to complaints in a timely manner, providing PCQO staff with training opportunities to improve written and oral communication, defining the role of PCQOs in overseeing complaints about contracted or private services, and improving documentation requirements.

The following concern raised with our office is an example of how a review board declined to examine an important aspect of a complaint because it decided that the complaint did not fall within its jurisdiction. (The name below has been changed to protect confidentiality.)

Marcia's Story

Marcia's mother lived in a residential care facility that was run by a health authority. Marcia had concerns about the care her mother was receiving and complained to the regional patient care quality office. She was not satisfied with the resolution that the office offered, so she took her complaint to the regional patient care quality review board.

Marcia had asked that her mother be transferred to another facility, as she was concerned that students, who were still in training, were providing care to her mother. The review board decided that it could not make a recommendation about the health authority's decision to not transfer her mother. The board's position was that because the health authority had made an operational decision, it was beyond the board's jurisdiction.

In Marcia's case, the patient care quality review board's decision meant that an important part of Marcia's complaint was not addressed. We could not find anything in the Act or the minister's directive that requires making a distinction between a health authority's operational decisions and other types of decisions health authorities make. If, in fact, the ministry expects the review boards not to examine decisions they consider "operational," this is not set out in any directive. Nor is there any description in any ministry directive of what constitutes an operational decision.

The ministry did explain that, in preparing recommendations, a patient care quality review board is expected to consider the health authority's role as manager of public resources, consider whether a recommendation might set a precedent that results in a greater impact on the health system than was originally intended, and consider the practicality of the recommendation. According to the ministry, "a board would be more likely to make recommendations regarding policy and process improvement rather than recommend compensation at the individual level."

¹⁰² Ministry of Health, *Patient Care Quality Review Boards Orientation Manual*, October 2008, 23.

¹⁰³ In 2009/10, 15 of the 104 recommendations made by PCQRBs related to improvements to the complaints process. Patient Care Quality Review Boards, *Annual Report*, 2009/10. In 2010/11, 25 of the 75 recommendations made by PCQRBs related to improvements to complaints processes. Patient Care Quality Review Boards, *Annual Report*, 2010/11.

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Time Limits for Processing Complaints

The Ministry of Health directive sets time limits for patient care quality offices (PCQOs) to respond to complaints. A PCQO has 30 business days to process a complaint, unless the complainant agrees to an extension.

Patient care quality review boards (PCQRBs) have a maximum of 120 business days to complete the entire review process and 10 business days after that to report back to the complainant. If a PCQRB makes a recommendation to a health authority, the health authority must respond formally within 30 business days. A PCQRB can fast track the review process when it considers this to be appropriate; however, there is no policy on when fast tracking can or should happen and no process outlining how to conduct an expedited review. In one case, a PCQRB issued interim recommendations pending the completion of its review.¹⁰⁴

If both the PCQO and the PCQRB comply with the timelines set out in the directive, without any extensions, the process takes eight months from start to finish. In some cases, during this time complainants may be going without services they believe they are eligible for, which raises concerns about the timeliness of resolutions.

Time Limits for PCQO Reviews

ASAP: *Following receipt of a complaint, a PCQO must decide if it is within the office's jurisdiction and inform the complainant of its decision.*

Within 2 business days: *A PCQO must acknowledge the receipt of a complaint and advise the complainant of the next steps.*

Within 30 business days: *A PCQO must complete processing the complaint (or obtain the agreement of the complainant to take more time to process the complaint).*

At least every 20 business days: *If an extension has been agreed to, a PCQO must update the complainant on the progress of the complaint.*

Within 10 business days after the processing of the complaint: *A PCQO must report, either verbally or in writing, to the complainant about how the complaint was resolved and inform the person of his or her right to request a review by the PCQRB.*

Time Limits for PCQRB Reviews

Within 5 business days: *PCQRBs must acknowledge the review request and confirm that the complaint is within their jurisdiction.*

Every 20 business days: *PCQRBs must update the complainant and the PCQO on the progress of the review.*

Within 120 business days: *PCQRBs must complete the review.*

Within 10 business days of completing the review: *PCQRBs must notify the complainant of the outcome of the review.*

¹⁰⁴ Patient Care Quality Review Boards, *Annual Report*, 2009/10, 26.

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Number of Complaints Received

The table below shows how many care quality complaints the PCQOs received between October 2008 and June 30, 2010. Approximately, 8 per cent of the complaints that PCQOs received in this 21-month period were about home and community care. Each health authority has between one and seven patient care quality officers, some of whom also have other responsibilities.¹⁰⁵ Based on this information, the workload for patient care quality officers seems quite heavy. For example, the five officers in the Fraser Health Authority dealt with 3,457 patient care quality complaints in this period. Given the volume of complaints and the limited resources available to respond to them, it is not surprising that actions taken to process and respond to complaints by patient care quality officers are limited.

Table 2 – Complaints to Patient Care Quality Offices, October 2008 to June 30, 2010

Health authority*	Population served (millions)	Number of staff in PCQO	Complaints received	Complaints related to care of seniors
FHA	1.573	5	3,457	135
IHA	0.733	6	1,145	143
NHA	0.285	1	332	39
VCHA	1.114	7 ¹	1,119	132
VIHA	0.749	4	1,457	165
Total²	4.454	23	7,510	614

* Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

¹ VCHA told us that these seven staff have other responsibilities in client relations and on the risk team, in addition to their PCQO roles.

² These figures exclude the Provincial Health Services Authority.

Between October 2008 and June 2010, the five regional PCQRBs completed 63 reviews of complaints about PCQO responses. Ten of the review requests involved the care of seniors.

¹⁰⁵ Some PCQO staff are also responsible for dealing with other complaints related to issues such as environmental health, food safety, drinking water and sewage disposal. These complaints are addressed through the health authority's client relations offices.

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Table 3 – Reviews Completed by Patient Care Quality Review Boards, January 2009 to June 2010 ¹⁰⁶

Health authority*	Completed reviews	Completed reviews related to seniors' care
FHA	14	1
IHA	17	5
NHA	1	0
VCHA	17	2
VIHA	14	2
Total	63	10

* Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

Public Information about Patient Care Quality Office and Review Board Processes

The minister's directive under section 6(1)(d) of the *Patient Care Quality Review Board Act*, requires patient care quality offices (PCQOs) to promote public awareness of their role through printed materials and links on the websites of health authorities and affiliated agencies. According to the directive, the website links should be easily identifiable icons on each site's home page and should connect directly to contact information for the PCQOs and patient care quality review boards (PCQRBs), their hours of operation, and an explanation of the complaints process.

When we reviewed the health authorities' websites, we found that they all advise people to try to resolve complaints with their care provider first. Then, if complaints cannot be resolved at that level, the websites tell people to contact their regional PCQO. Each of the health authorities has a link on its home page that leads to information on how to complain to its PCQO.

Although the health authority websites describe how to make complaints to the PCQOs, there is variation in the information they provide about the process. Explanations of the types of complaints the PCQOs will accept, the steps involved in the complaints process and the time limits for reviews differ from one health authority to another. While such variation may be useful, if it serves local needs and priorities, it does not reflect the standard Ministry of Health policy. The health authorities have taken some positive steps to publicize the role of the PCQOs. However, the information provided does not ensure that the public has access to clear, consistent and comprehensive information about their roles.

¹⁰⁶ The boards were launched in October 2008. They completed their first review in January 2009.

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The regional PCQRBs have one central website that provides information about the review board process.¹⁰⁷ This website describes how to complain and how the boards review and respond to complaints. There is also information on the types of complaints the PCQRBs will and will not review. This provides a useful model for the PCQOs to provide the same type of information as the review boards.

Ombudsperson's Review of Files from Patient Care Quality Offices and Review Boards

Given the broad scope of complaints that the patient care quality offices and the review boards handle, and their potential role in responding to complaints about the care of seniors, we reviewed how they have responded to complaints since opening in October 2008.

We received the following complaint that highlights one of the issues that can arise when PCQOs do not conduct their own assessments of complaints. (The names below have been changed to protect confidentiality.)

Kathryn's Story

Kathryn contacted us because she was concerned about the care her father Arthur was receiving in a residential care facility. Arthur, who had significant physical restrictions, preferred to remain in his room most of the time, including for meals. Kathryn thought that her father was not always positioned comfortably and safely in his wheelchair. She was also concerned that he could not always access water or his call bell.

Since Kathryn lived outside the province, she was only able to visit her father every few months. Nonetheless, she raised her concerns about his care several times with both the facility's manager and its care coordinator. She also arranged for a friend to visit her father and represent her interests and concerns.

In December 2009, Kathryn complained to the health authority's patient care quality office. In her written correspondence with the PCQO, she stated that she had taken her concerns about her father's care to the facility manager but had not been satisfied with his response.

In February 2010, the PCQO manager responded in writing to Kathryn's complaint. He said that the PCQO had forwarded her complaint to the facility manager for investigation. The PCQO manager attached the facility manager's letter of response, which was intended to address Kathryn's complaint. The PCQO said that it hoped the letter from the facility manager addressed Kathryn's concerns, and referred her to the patient care quality review board, if she remained dissatisfied. Kathryn was surprised that the PCQO had simply sent her complaint to the facility manager to investigate, since she had told the PCQO that she had already attempted to resolve it with him.

Kathryn asked the PCQRB to review the PCQO's handling of her complaint. She received the review board's decision in November 2010 and it recommended changes be made to her father's care plan. Kathryn said about two months after the board's decision, her father's care plan was changed.

Understandably, Kathryn was not satisfied with the PCQO's response to her complaint. She had expected that it would conduct its own review of her concerns and not merely repeat the actions she had already taken. Kathryn told us that it required considerable tenacity on her part to pursue her concerns with the facility and the patient care quality review board.

¹⁰⁷ See www.patientcarequalityreviewboard.ca.

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Review of Files from Patient Care Quality Offices

Ombudsperson staff reviewed a total of 30 files from the patient care quality offices for the five health authorities. These files included complaints about home support, assisted living and residential care. These files represented 35 per cent of the 137 reported complaints about the care of seniors that the PCQOs received between October 2008 and June 2009.

We observed that the usual practice in all health authorities was for PCQO officers to refer complaints back to the health authority staff who were either involved with the services in question or connected to the contracted agency. In only four of the files we reviewed did PCQO staff clearly take steps to address the concern directly. In three cases, PCQO staff referred the complaints to the local community licensing office. In the remaining cases, PCQO staff referred the complaints generally back to the facility or health authority staff who were involved with the services in question in the first place. The documentation was not always clear about whom the complaint was referred to. In most of the files, PCQO staff checked that the person they referred a complaint to actually did respond to it. However, in some cases, there was no indication that PCQO staff had followed up on the referral they had made back to health authority staff.

In the files we reviewed, it was not always clearly documented that PCQO officers had informed people of the outcome of their complaint. This is required by the *Patient Care Quality Review Board Act* and is an important step in any complaints process, particularly where there is a right of review or appeal. Complainants should always be given a written explanation of what was decided, the grounds for the decision and information on options for further review, if available. In 8 of the 30 files we reviewed, it was clearly documented that the complainant had been informed of the outcome in writing. Notations indicated that a further 7 complainants were informed of the outcome by telephone. The remaining 15 files did not contain enough information to clearly indicate that the complainant had been informed at all.

All the letters to complainants that we reviewed were from the Vancouver Coastal Health Authority's patient care quality office. In the files we reviewed, the Vancouver Coastal Health Authority PCQO was the only patient care quality office that had taken the time to provide complainants with written information on the outcome of their complaints — information that is required by legislation. The letters clearly documented the complaint and the applicable policies, and informed the complainant of his or her right to pursue the complaint with the patient care quality review board. However, it is not possible to verify that staff provided this same information when they communicated the outcome of a complaint by phone.

Despite the minister's directive requiring PCQOs to record the steps of the complaint process, this was not always done in a clear manner. The health authorities do not have clear and consistent practices for documenting the steps taken to process a complaint, and, in particular, for informing complainants of the outcome of this process.

In 23 per cent of the files we reviewed, the patient care quality offices did not process and respond to complaints within the required time limits. It was not recorded in the files we reviewed that extensions were requested and agreed to by complainants.

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Review of Files from Patient Care Quality Review Boards

Ten of the 63 reviews that the patient care quality review boards completed between January 2009 and June 2010 involved the care of seniors. Six of these files were about residential care, two were about home support services and two were about acute care discharge planning. Ombudsperson staff reviewed how these 10 complaints were dealt with.

Overall, the reviews were well-organized and thorough. The receipt of files was documented, as were subsequent information requests. The reviews were completed within the required time limit of 120 business days.¹⁰⁸ In seven of the ten files that we examined, when the PCQRB found that a problem was linked to inadequate policies, it recommended that the policies be reviewed. PCQRB recommendations often focused on encouraging the health authorities to review existing policies or improve existing policies.

We also looked at the patient care quality review boards' first annual report, which was published in June 2010, to determine whether the PCQRB recommendations tend to be aimed at policy improvements or the resolution of individual complaints. We found that 22 of the 85 recommendations made to the health authorities could be categorized as "individual," in that they recommended that the health authorities take specific steps to respond to one or more issues raised by a complainant.¹⁰⁹ These individual recommendations constituted approximately 25 per cent of the total. The overall focus on improvements to system-wide processes appears to be consistent with the focus of the legislation. However, it is important to note that the PCQRBs often make multiple recommendations about each complaint. Taking this into account, we found that an individual recommendation was made in 20 of the 36 cases reviewed, or 56 per cent of the time.

"When individuals have concerns about the quality of care they or a loved one received, it is important that those concerns are appropriately and adequately addressed. This helps to restore the patient's trust and confidence in the health care system, and, on a broader scale, creates opportunities for the health care system to learn from each patient experience. To that end, the Patient Care Quality Review Boards play a central role in enabling those concerns to be heard, to be carefully considered, and to generate ideas for quality improvement at the local, regional and system-wide level."

Source: Patient Care Quality Review Boards, *Annual Report, 2009/10*.

Analysis

The role of the patient care quality offices and review boards in handling quality care complaints has a number of positive features. There are specific timelines for each step in the process, which minimizes unnecessary delays. People who are dissatisfied with the outcome of their complaint to a PCQO can pursue it further by requesting a review by the PCQRB. Each health authority has information on its website informing the public about how to make a complaint to the patient care quality office and the ministry has a website that provides information about the review board process. There are, however, some areas where improvements can be made.

¹⁰⁸ This works out to 24 weeks or 5½ months.

¹⁰⁹ There were no requests for review in the Northern Health Authority during this time period, and therefore no recommendations were made to this health authority.

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One of the most significant difficulties with the current complaints process is the lack of consistent province-wide guidelines for how the patient care quality offices actually process complaints. Neither the *Patient Care Quality Review Board Act* nor the Minister's directive provide adequate guidance on how the patient care quality offices should respond to complaints or the information they should consider before attempting to resolve them. Although the directive requires the PCQOs to document the steps taken to resolve a complaint, the health authorities do not appear to have developed a consistent process for implementing this requirement. A consistent province-wide process would include a definition and examples of the steps that PCQOs must take to respond to complaints. While PCQOs are required to report the outcome of a complaint to the complainant, they are not required to do so in writing. Adding a requirement to report the outcome of a complaint in writing would assist complainants in understanding the result of their complaint and help them in deciding whether they wish to proceed to a review.

In the absence of a well-defined process for responding to complaints, and working with limited resources, patient care quality offices often refer complaints back to the health authority staff who were involved in providing the care in question and then communicate their response to the complainant. In the files we reviewed, we observed that PCQO staff did not consistently analyze the issues or make their own determinations of whether the responses offered were appropriate. This approach creates a disconnect between what the public expects is an independent review and what actually happens.

PCQO websites do not clearly identify the kinds of complaints that the patient care quality offices will and will not consider. Providing this information could help the public to better understand the role of the PCQOs and direct their complaints accordingly. In addition, the ministry should publish the contents of the Minister's directive which includes time limits on its website. Doing so would increase the overall transparency of the complaints process.

PCQRBs have 120 business days to complete their review of a complaint. When complaints are urgent, the review boards can speed up a review as they see fit, but there is no guidance on how and when this should occur. Publishing a directive on when to consider complaints urgent would help ensure timely responses.

While there are positive features of patient care quality review processes, as discussed above, there is still work that can be done to make the complaints process a truly effective means of dealing with health care issues.

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The Ombudsperson finds that

- F15. The Ministry of Health has not provided specific direction to the patient care quality offices (PCQOs) on the steps they should follow in processing care quality complaints.

The Ombudsperson recommends that

- R16. The Ministry of Health provide specific direction to the PCQOs on the steps they should follow in processing care quality complaints.
- R17. After the PCQOs and patient care quality review boards (PCQRBs) have been operational for five years, the Ministry of Health review their complaint-handling processes and implement any improvements identified in the course of this review.

The Ombudsperson finds that

- F16. The Ministry of Health has not established a policy on when PCQRBs should treat requests for reviews as urgent.

The Ombudsperson recommends that

- R18. The Ministry of Health develop and make public a clear policy to guide the PCQRBs on when they should treat review requests as urgent.

The Ombudsperson finds that

- F17. The health authorities' PCQOs do not consistently:
- provide information to the public about which complaints they will consider
 - document the process they use when responding to complaints
 - provide written reasons to complainants at the end of a review
 - record whether complainants were advised of their option to take their complaints to the regional patient care quality review board

The Ombudsperson recommends that

- R19. The health authorities provide clear and consistent information to the public on how the PCQOs respond to complaints and the complaints they will consider.
- R20. The health authorities ensure that PCQOs carefully document the steps taken in response to a complaint as set out in the ministerial directive.
- R21. The health authorities ensure that PCQOs inform all complainants in writing about the outcome of their complaint.

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Community Care and Assisted Living Appeal Board

The Community Care and Assisted Living Appeal Board was created in 2004. It is an administrative tribunal that hears appeals under section 29 of the *Community Care and Assisted Living Act (CCALA)*. More specifically, the board hears appeals on licensing, regulation and certification decisions made about facilities that are licensed under the *CCALA*, as well as appeals of decisions about the certification of early childhood educators. An example of a decision that the board might hear on appeal is a reconsideration decision made by a health authority's medical health officer on whether to refuse, suspend, cancel or attach conditions to a facility's licence. In this case, a facility operator who disagreed with the reconsideration decision made by a medical health officer could appeal this decision to the appeal board. In addition, a person in care, or the spouse, relative or friend of a person in care, can appeal a medical health officer's decision to exempt (under section 16 of the *CCALA*) a facility from complying with a part of the Act.

When reviewing these decisions, the appeal board can look at new information as well as at the information that was available when the initial decision was made. The *CCALA* gives the board the authority to confirm, reverse or vary a decision, or send the decision back for reconsideration, either with or without instructions.

Only 4 of the 32 cases the board has considered since 2004 have been about adult residential care facilities. In two of these cases, the facility operators appealed a reconsideration of a decision made about their licence. The other two cases, *BG and FS v. Fraser Health Authority and Valleyhaven Guest Home* and *Twenty-four Residents v. Vancouver Island Health Authority and Cowichan Lodge*, were appeals of decisions made by medical health officers to exempt the operators from providing 12 months notice of the closure.

Need for Advocacy and Support

Advocacy and support play a critical role in a system where seniors are vulnerable and face barriers to raising concerns. Currently, with the exception of the role played by resident and family councils, advocacy and support do not have a clearly defined role in home and community care services.

Access to advocacy and support is an essential complement to an effective complaints process, particularly where complainants face physical and cognitive challenges and are highly dependent on the services they receive and the individuals they may complain about. As we noted in the *Best of Care: Getting It Right for Seniors in British Columbia (Part 1)*, not all seniors have family or friends who can advocate for or support them when care concerns arise. Without advocacy and support, the concerns of these seniors may never be raised or addressed.

Many complaints about home and community care services are made on behalf of seniors by friends and family. This is particularly true of seniors in residential care facilities and assisted living residences, which is not surprising given that one of the conditions of eligibility for these types of care is the need for assistance with daily activities. In addition to friends and family, advocacy may come from resident and family councils or other groups, all of whom can help residents by asking questions, raising concerns and navigating the system.

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While seniors who aren't supported by friends and family face obvious barriers in raising concerns, families may also have difficulty doing so without outside assistance. In the course of our investigation, families told us that it wasn't always clear to them who was responsible for responding to complaints, particularly when services are provided by contracted agencies. They also told us that they were sometimes reluctant to raise concerns because they didn't want to be labelled as complainers and feared that the care their loved ones received would suffer. In addition, families who have recently placed a relative in a facility often face a period of adjustment and may not have the time, energy or knowledge necessary to raise their concerns effectively.

Advocacy is necessary for seniors to ensure that their voices are heard, their rights are respected and their needs are met. Currently, with the exception of the role of resident and family councils, advocacy does not have a clear, mandated role in home and community care services.

In British Columbia there is a provincial ministry and a representative whose focus is vulnerable children needing care and support. Currently, there is no equivalent for vulnerable seniors needing care and support. At various times in the past, British Columbia had a ministry responsible for seniors. While the Office of the Ombudsperson investigates complaints about seniors' care, it does not have a mandate to provide advocacy support.

The Ombudsperson finds that

F18. The Ministry of Health has not ensured that seniors and families have access to adequate assistance and support to navigate the complex home and community care system and bring forward concerns and complaints.

The Ombudsperson recommends that

R22. The Ministry of Health establish a program to provide support for seniors and their families to navigate the home and community care system and bring forward concerns and complaints by January 2013.

Training and Qualifications for Community Health Workers

Community health workers, often referred to as home support workers, care aides or resident care attendants, are on the front lines of seniors' care. They provide care and help seniors with daily activities such as getting up, washing, dressing, eating, going to the bathroom and moving around. They work in private homes, in assisted living residences and in residential care facilities.

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Recruitment and retention of trained staff is a major challenge for agencies that provide home and community care services to seniors. In the course of our investigation, we heard the following concerns about staff education and training:

- staff need more skills in order to cope with the increasingly complex needs of seniors in residential care facilities
- staff need specific training on caring for residents with dementia
- care aides lack consistent training and education standards
- staff at all levels would benefit from ongoing professional development opportunities

Education and Training

Over the past 35 years, the development of training programs for community health workers has resulted in the transition from on-the-job training by the employer to training by educational institutions. Today most job seekers must complete some type of training program prior to employment. A number of publicly funded colleges and private training institutions currently offer certificate programs for community health workers. As well, some home support agencies offer their own in-house training programs.

Before 2007, the Ministry of Health did not have specific training and skills requirements for community health workers. That changed when the Ministry of Health published a document called the *Framework of Practice for Community Health Workers and Resident Care Attendants*. This policy framework sets out what the ministry believes are the skills and qualities that community health workers should have.¹¹⁰ The framework provides a general outline of the principles that underlie community health practice and the skills these workers are expected to have.

Also in 2007, a cross-section of home and community care managers and educators began to modernize the curriculum for community health worker programs. The ministry supported this project and the new curriculum, completed in 2008, which is based on its policy framework. The Ministry of Advanced Education told us that all 16 public post-secondary institutions that offer training programs for community health workers now follow the new curriculum.

In addition to the public institutions, 30 of the private institutions that offer these training programs have signed licensing agreements that allow them to use the curriculum. However, private colleges can still use any curriculum they wish and are not required to use the one endorsed by the ministry. This means that students in private institutions may graduate without the training and skills the ministry believes community health workers should have and which it requires public institutions to provide. In view of the effort invested in overhauling the curriculum and the fact that graduates from both types of programs provide care and support to seniors in British Columbia, it is unclear why the government has not required both public and private institutions to use it. It would clearly be in the interests of students, seniors and employers to have the certainty that all community health workers receive the same level of training.

¹¹⁰ Ministry of Health, *Framework of Practice for Community Health Workers and Resident Care Attendants*, Care Aide Competency Project, 2007
<http://www.health.gov.bc.ca/library/publications/year/2007/CareAideCompetencyProjectFramework.pdf>.

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The Ombudsperson finds that

F19. The Ministry of Health has not ensured that all institutions offering training for community health workers are using its approved new curriculum.

The Ombudsperson recommends that

R23. The Ministry of Health work with the Ministry of Advanced Education to require all institutions offering training for community health workers to use the approved new curriculum commencing in September 2013.

Registration

In January 2010, the Ministry of Health announced the creation of the BC Care Aide & Community Health Worker Registry.¹¹¹ Although all community health workers are encouraged to register, only community health workers employed by agencies that receive public funding to provide home support, assisted living or residential care services must be registered.

According to the registry's website, its mandate is to:

- protect vulnerable patients, residents and clients
- establish and improve standards of care in the care aide and community health worker occupations
- promote professional development for community health workers
- assist these workers in identifying career opportunities

Applications can be completed online, mailed or faxed to the registry, and there is no cost for registration. Publicly funded employers must verify that a prospective employee is registered prior to hiring that individual.

All publicly funded agencies that provide care to seniors are obligated to send a written report to the registry each time a registered employee is suspended or terminated on the grounds of alleged abuse. The definition of abuse used by the registry is the same as the definition in the *Residential Care Regulation* of the *Community Care and Assisted Living Act*, which states, “a licensee must ensure that a person in care is not, while under the care or supervision of the licensee, subjected to (a) financial abuse, emotional abuse, physical abuse, sexual abuse or neglect as those terms are defined in section 1 of Schedule D, or (b) deprivation of food or fluids as a form of punishment.” The obligation of a contracted agency to report disciplinary actions taken to address instances of abuse to the registry is part of the agency's contract with the ministry.¹¹² When the registry receives such a report, it suspends that employee's registration. Registration cannot be reinstated until the person is cleared by an investigation conducted by the employer, or by another process overseen by the registry.

¹¹¹ Ministry of Health, BC Care Aide & Community Health Worker Registry, “Home” <<http://www.cachwr.bc.ca/>>.

¹¹² *Residential Care Regulation*, B.C. Reg. 96/2009, s. 52(1).

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While the provincial government has encouraged all community health workers who provide care for seniors to register, currently it is only those who work for publicly funded agencies who are actually required to do so as a condition of employment. In the January 29, 2010, news release that announced the creation of the registry, the government indicated that it intended for the registry to eventually cover community health workers at all agencies and facilities, but it did not provide a timeline for this expansion. To date the ministry has taken no action.

Table 4 – Community Health Worker Registration Requirements

Registration required	Registration not required
<ul style="list-style-type: none"> • Trained in a public college • Working in a publicly funded organization 	<ul style="list-style-type: none"> • Trained in a public college • Working in an organization that does not receive public funding
<ul style="list-style-type: none"> • Trained in a private college • Working in a publicly funded organization 	<ul style="list-style-type: none"> • Trained in a private college • Working in an organization that does not receive public funding
<ul style="list-style-type: none"> • Trained in-house by the employer • Working in a publicly funded organization 	<ul style="list-style-type: none"> • Trained in-house by the employer • Working in an organization that does not receive public funding

The government's delay in requiring registration by those who work for employers that do not receive public funding creates a troubling gap in the protection of seniors that registration was designed to improve. In fact, only those community health workers who work within a publicly funded organization must be registered. An agency or facility that does not receive public funding is not obligated to report any suspensions or terminations in response to alleged abuse, and its employees do not have to register. No public record is created when one of these employers suspends or fires a community health worker on the grounds of alleged abuse.

The government's rationale for exempting this group of community health workers from the registration requirement is unclear. Regardless of how they are funded, all agencies and facilities hire staff from the same pool of prospective employees, and all those employees provide care to the same population of seniors. The purpose of the registry is to protect the public — particularly vulnerable seniors — by collecting and documenting instances of community health workers who have been suspended or fired because they abused someone they were caring for. The effectiveness of the registry is compromised because community health workers are not required to register if they work at facilities or agencies that are not publicly subsidized or funded. The ministry could address this gap by requiring all community health workers to register and all service providers to file reports on disciplinary actions they have taken in response to reports of abuse.

Community health workers seeking to register have had to provide their training credentials and education details. New applicants must also supply two letters: one that provides a character reference and one that speaks to their qualifications and skills. Presumably, the requirement to provide these letters will prevent anyone from registering who had been suspended or fired in the past for suspected abuse. However, the registration process does not specifically require applicants to disclose their disciplinary record and so people who have a disciplinary record that includes abuse may still be able to register. In fact, for the first

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five months after the government created the registry in January 2010, anyone who was employed as a community health worker could register without having to satisfy any other requirements. This meant that even those who had previously been subject to disciplinary action could register.¹¹³

If the intention of creating the registry was to ensure that employers have access to information on whether potential employees have been disciplined for abuse, that purpose has not yet been fulfilled. Creating the registry was a useful step, but there are significant gaps that still need to be addressed. This is especially true since, unlike other health care workers, community health workers do not have to belong to or meet the standards and requirements of a professional association. This makes it even more important that all community health workers be required to register, regardless of their employer's sources of funding.

The Ombudsperson finds that

F20. The Ministry of Health does not require care aides and community health workers at home support agencies, assisted living residences and residential care facilities that do not receive public funding to register with the BC Care Aide & Community Health Worker Registry.

The Ombudsperson recommends that

R24. The Ministry of Health, by January 2013, require care aides and community health workers at all home support agencies, assisted living residences and residential care facilities to register with the BC Care Aide & Community Health Worker Registry.

The Ombudsperson finds that

F21. The Ministry of Health does not require applicants to the BC Care Aide & Community Health Worker Registry to disclose whether they have ever been subject to formal disciplinary action by a health care employer.

The Ombudsperson recommends that

R25. The Ministry of Health require applicants to the BC Care Aide & Community Health Worker Registry to disclose whether they have ever been disciplined or terminated by a health care employer on the grounds of abuse, and establish a process for evaluating whether it is appropriate to allow registration.

¹¹³ Ministry of Health, BC Care Aide & Community Health Worker Registry, "FAQ" <<http://www.cachwr.bc.ca/FAQ.asp?NavPage=15&Ticket=>>.

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Criminal Record Checks

Under the *Criminal Records Review Act*, certain employers are required to ensure that every person they intend to hire for work involving “vulnerable adults” undergoes a criminal record check.¹¹⁴ Under section 1 of the Act, a “vulnerable adult” is defined as “an individual 19 years or older who receives health services, other than acute care, from a hospital, facility, unit, society, service, holder or registrant.”¹¹⁵ A criminal record check is a record search conducted by a police department to determine whether a person has ever been convicted of a crime.¹¹⁶ The Criminal Records Review Program within the Ministry of Public Safety and Solicitor General is responsible for processing and investigating criminal record checks under the Act to determine whether a person may pose a risk of physical, sexual or financial abuse to vulnerable adults.

Under the *Criminal Records Review Act*, prospective employees must provide a criminal records check authorization to an employer. The Act also requires existing employees to provide their employer with an authorization for a criminal record check and to update this authorization every five years.¹¹⁷ Employees must also inform their employer of any new charges or convictions.¹¹⁸ If a criminal record check uncovers an outstanding charge or conviction that indicates that the person presents a risk of physical, sexual or financial abuse to vulnerable adults, the employer must not hire a prospective employee or allow an existing employee to work with vulnerable adults.¹¹⁹

Previously, such checks were required only for people working with children. However, the Act was amended on January 1, 2011, and now requires criminal record checks for people who work with vulnerable adults when the employer:

- is a health authority that operates a hospital, mental health facility or service, facility or service related to medical or health care, or to a private hospital as defined in the *Hospital Act*
- receives health authority funding to operate a hospital, mental health facility or service, facility or service related to medical or health care, or to a private hospital as defined in the *Hospital Act*
- operates a residential care facility licensed under the *Community Care and Assisted Living Act (CCALA)*
- operates an assisted living residence

These amendments mean that all operators of assisted living and *CCALA* residential care facilities, regardless of how they are funded, must obtain criminal record checks on current and new employees. These provisions also include home support workers who are employed by a health authority and health authority employees who work in extended care hospitals.

¹¹⁴ *Criminal Records Review Act*, S.B.C. 1996, c. 86, ss.1 and 9.

¹¹⁵ *Criminal Records Review Act*, S.B.C. 1996, c. 86, s. 1. Section 1 of the Act also separately defines “work with vulnerable adults” as working with vulnerable adults directly or (potentially) having unsupervised access to them in the course of work or education.

¹¹⁶ The fee payable for a criminal record check is \$20. *Criminal Record Check Fee Regulation*, B.C. Reg. 238/2002, s. 1(1).

¹¹⁷ *Criminal Records Review Act*, S.B.C. 1996, c. 86, s. 10.

¹¹⁸ *Criminal Records Review Act*, S.B.C. 1996, c. 86, s. 12(1).

¹¹⁹ *Criminal Records Review Act*, S.B.C. 1996, c. 86, s. 11.

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The *Criminal Records Review Act*, however, does not require prospective or current employees of private hospitals or home support agencies that do not receive public funding to obtain criminal record checks as a condition of working with vulnerable adults.

As vulnerable adults, seniors should receive the same level of protection regardless of who they receive services from. Criminal record checks are a way of minimizing the risk to seniors from those who may take advantage of them. The justification for excluding privately funded home support services and privately funded private hospitals from the criminal record check requirements is not clear. The ministry should take steps to address the above gaps to ensure that all seniors requiring home and community care services are equally protected.

The Ombudsperson finds that

F22. The Ministry of Health has not taken adequate steps to ensure that employers of home support agencies and private hospitals that do not receive public funding obtain criminal record checks on persons who work with vulnerable adults as a condition of employment.

The Ombudsperson recommends that

R26. The Ministry of Health, in consultation with the Ministry of Solicitor General, take all necessary steps by June 2013 to ensure that all persons who work with vulnerable adults in home support agencies and private hospitals are required to obtain criminal records checks as a condition of employment.

Reporting and Responding to Allegations of Abuse and Neglect

Seniors who are receiving home and community care services are vulnerable because they require some level of care. This is true whether they are receiving home support services in their own homes or are being cared for in assisted living or residential care facilities. This vulnerability means that those who oversee and provide care for seniors have a duty to protect them from harm. This duty should include a responsibility to report concerns if and when they arise. The various legislative requirements to report and respond to allegations of senior abuse or neglect are discussed below. As will be evident, the level of protection provided by requiring abuse and neglect to be reported varies considerably.

Requirements of the *Adult Guardianship Act*

Part 3 of the *Adult Guardianship Act (AGA)* is intended to provide support and assistance to adults who are abused or neglected and who cannot seek support due to a physical restraint, physical handicap that limits their ability to seek help, or a condition that affects their decision-making ability about the abuse or neglect.¹²⁰ Other adults who are vulnerable but who are able to seek support are not similarly protected.

¹²⁰ Part 3 of the *AGA* consists of sections 44 through 60.1, and is entitled “Support and Assistance for Abused and Neglected Adults.”

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Under section 46(1) of the *Adult Guardianship Act*, anyone who has information indicating that a vulnerable adult is being abused or neglected can choose to report it to one of the agencies designated by the public guardian and trustee, but is not required to do so. The designated agencies include all five regional health authorities, Providence Health Care Society and Community Living BC. The Act applies to abuse or neglect that occurs in any setting, including private homes, hospitals, assisted living residences and residential care facilities, regardless of how they are owned or funded.

Given that the people whom Part 3 is designed to protect are unable to seek protection themselves, they must rely upon others to voluntarily report in order to receive protection.

Reporting abuse or neglect under the Act is voluntary. It can be argued that a benefit of making reporting voluntary instead of mandatory is that doing so gives more weight to seniors' autonomy, which should be an important consideration. Mandatory reporting under the Act, however, would not undermine the autonomy of the adult, and there are cases in which reporting abuse or neglect of seniors should be made mandatory. Specifically, people who work with seniors are often in the best position to observe incidents of abuse or neglect and should be required to report reasonable suspicions of abuse or neglect to the health authorities or public guardian and trustee.

The current approach under the *Adult Guardianship Act* is very different from the approach taken in the provincial *Child, Family and Community Service Act*, which requires any person who believes that a child is in need of protection to report this belief to the government. That Act makes it an offence not to report this belief.¹²¹

The approach taken by the *Adult Guardianship Act* also contrasts with that taken in other provinces. For example, in the residential care context, Ontario's *Long-Term Care Homes Act* requires a person who has reasonable grounds to suspect that any of the following has occurred to report the suspicion and information immediately:

- improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident
- abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident
- unlawful conduct that resulted in harm or a risk of harm to a resident
- misuse or misappropriation of a resident's money
- misuse or misappropriation of funding provided to a licensee

Reporting Abuse and Neglect

Section 46(1) of the *Adult Guardianship Act* states:

Anyone who has information indicating that an adult

- (a) is abused or neglected, and*
- (b) is unable, for any of the reasons mentioned in section 44, to seek support and assistance,*

may report the circumstances to a designated agency.

The inability of the adult to seek support and assistance may stem from a physical restraint, a physical disability, or a condition that affects the adult's ability to make decisions about abuse or neglect.

¹²¹ *Child, Family and Community Service Act*, R.S.B.C. 1996, c. 46, s. 14(1) and (3).

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In addition, in Ontario, if a licensee, staff member or person who provides professional services to a resident or a licensee in the areas of health, social work or social services fails to make a report, that person is guilty of an offence under the *Long-Term Care Homes Act*.

Reports of Abuse or Neglect to Health Authorities

Under section 47(1) of the *Adult Guardianship Act (AGA)*, a health authority that receives a report of abuse or neglect must determine if the person who is the subject of the report needs support and assistance. If so, the health authority may do one or more of the following:

- refer the person to available health care, social, legal, accommodation or other services
- assist the person in obtaining those services
- inform the public guardian and trustee
- investigate to determine if the person is abused or neglected and is unable, for any of the reasons mentioned in section 44 of the Act, to seek support and assistance

We asked the health authorities to tell us how many times they had provided emergency assistance to an adult under the *AGA* since it came into force in 2000. They were not able to do so because they only document these investigations in individual case files and do not have a way of tracking the overall number they conduct. It is therefore not possible to determine how many reports of abuse or neglect of adults the health authorities receive or whether that number is going up or down from year to year.

When health authority staff confirm that abuse or neglect has taken place and that a senior requires assistance, they have authority to take a number of actions. These can include:

- helping the senior to find a representative
- preparing a support and assistance plan
- filing a police report
- applying for a court order
- reporting the case to the public guardian and trustee¹²²

In addition, section 50 of the *AGA* indicates that if a designated agency has reason to believe that a criminal offence has been committed against an adult who is subject of a report under section 46, the designated agency must report it to the police.

Requirements of the *Community Care and Assisted Living Act* and *Residential Care Regulation*

While the *Adult Guardianship Act (AGA)* applies to seniors in any setting, seniors who live in residential care facilities that are licensed under the *Community Care and Assisted Living Act (CCALA)* benefit from an additional level of protection. This comes from the provision of the *CCALA* that states that a person in a licensed residential care facility has the right to be protected from abuse and neglect and to the “protection

¹²² *Adult Guardianship Act*, R.S.B.C. 1996, c. 6, s. 59.

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and promotion of his or her health, safety and dignity.”¹²³ Some of this protection comes from section 77 of the *Residential Care Regulation*, which deals with reportable incidents. This section of the Regulation states that when a resident has been involved in or has witnessed a reportable incident, operators must notify the resident’s family and medical practitioner, the regional medical health officer and a representative of the funding program, if applicable.¹²⁴ Schedule D of the Regulation lists 20 reportable incidents, including four types of abuse: emotional, financial, physical and sexual. The reportable incident requirements create an obligation for operators to report incidents they are aware of.

A serious gap in Schedule D’s list of reportable incidents is that abuse carried out by one resident against another is not included. However, during the course of this investigation, the Ministry of Health’s director of licensing issued a standard of practice under section 4 of the *CCALA* effective September 1, 2011, which is aimed at correcting this gap. (Further information about this gap and the director of licensing’s directive can be found under “Reportable Incidents” in the Residential Care section of this report.)

Operators of residential care facilities governed under the *Hospital Act*, however, are not subject to the *CCALA*’s reportable incident requirements, and the *Hospital Act* does not contain comparable provisions. Accordingly, seniors in *Hospital Act* facilities do not benefit from the added protection of the *CCALA*’s reporting requirements, and as in home support and assisted living, staff and operators may but are not required to report abuse or neglect of a vulnerable adult.

Involving the Police

There are no clear guidelines that outline when community health care workers, facility staff or health authority employees should report incidents of abuse and neglect to the police. It can be difficult for facility operators and health authority staff to determine when physical, emotional or financial abuse has crossed the line and become criminal behaviour. In comparison, operators in Ontario are required to immediately notify the police of any alleged, suspected or witnessed incident of abuse or neglect that the operator suspects may constitute a criminal offence.¹²⁵

In some cases, families disagree with the decisions that facility or health authority staff make about reporting to the police. The complaint we received from Bonnie is one such example. The situation that Bonnie’s mother was in when an incident occurred is one that currently provides a resident with the most protection under existing laws and regulations. (The names below have been changed to protect confidentiality.)

Criminal Code Offences that May Be Relevant to Abuse or Neglect

Physical abuse: *assault* (sections 265 to 268)

Emotional abuse: *uttering threats* (section 264.1); *harassment* (section 264(1)); *intimidation* (section 423)

Financial abuse: *theft* (section 322); *fraud* (sections 386, 387, 388)

Neglect: *criminal negligence* (section 219); *failure to provide the necessities of life* (section 215)

Source: Canadian Network for the Prevention of Elder Abuse
<<http://www.cnpea.ca>>.

¹²³ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, Schedule 1(2).

¹²⁴ *Residential Care Regulation*, B.C. Reg. 96/2009, s. 77(2). The “representative of the funding program” would be the case manager within the home and community care division of the health authority that provides funding to the resident if he or she is receiving subsidized services.

¹²⁵ *General Regulation* made under Ontario’s *Long-Term Care Homes Act*, O. Reg. 79/10, s. 98.

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Bonnie's Story

Bonnie contacted us about her mother Anne, who had dementia and was living in a residential care facility. Bonnie was concerned about a number of issues, including how facility management had responded to a report that a care aide had physically abused her mother. An employee had told management that she saw a care aide handle Anne roughly enough to cause bruising while changing her. Management conducted an initial investigation, then suspended the care aide, pending the results of a full investigation.

Because the facility was licensed under the CCALA, management was required to report the incident to the health authority's community care licensing office. Licensing staff then investigated and confirmed the allegation of physical abuse. They also noted that it was the fourth time in five years that they had investigated such an allegation at the facility and that two of these allegations had been confirmed.

Licensing staff required the facility's management to develop a detailed plan before allowing the care aide back to work. Management submitted a plan for reorienting and monitoring the care aide. The plan also stated that the care aide would be instructed not to provide care to Anne. Changes to the plan could only be made with the approval of licensing staff.

However, Bonnie remained concerned that no one at the facility or the licensing office had treated the incident as an assault that needed to be reported to the police. Bonnie went ahead and contacted the police herself, but still believed it was unreasonable that the health authority had not done so, especially since many residents didn't have family or friends to act on their behalf.

The health authority told us that neither the facility's management nor the health authority's licensing staff involved the police because there did not appear to be evidence of a criminal act. Their position was that since the care aide had not intended to cause harm, reporting to the police was not necessary.¹²⁶

Bonnie felt strongly that the police should be informed about the incident and she contacted them herself. As a result of her actions, a police investigation took place, though ultimately criminal charges were not proceeded with.

Given the vulnerabilities of seniors in residential care and the fact that many of them do not have family to act on their behalf, health authorities and facility staff cannot leave it to families and friends to report such incidents to the police. Criminal abuse of seniors, who are already in a vulnerable position, may not be reported to the police as a result.

¹²⁶ Had the incident taken place after June 29, 2010, facility management would have been required to report the suspension to the BC Care Aide & Community Health Worker Registry.

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Table 5 – Legislative Requirements for Reporting Abuse and Neglect of Seniors

	<i>Adult Guardianship Act</i>	<i>CCALA</i>
Who can report?	Anyone who suspects abuse or neglect of a senior unable to seek help	Operators of residential care facilities under the <i>CCALA</i>
Is reporting mandatory?	No	Yes
What is reported/ in what setting?	Suspected abuse or neglect in any setting, including home support, assisted living and residential care	“Reportable incidents” as defined by the <i>Residential Care Regulation</i> that occur in residential care facilities under the <i>CCALA</i>
Whom is reported to?	Agency designated by the <i>AGA</i>	Family and medical practitioner of person in care, regional medical health officer and the funding program

Analysis

It must be recognized that some adults are more vulnerable than others. While it is important to respect each adult’s right to autonomy and self-determination, the fact that those who work with seniors are not required to report suspected abuse or neglect does not reflect the important role these people play in protecting seniors.

The *CCALA* contains some additional protection for seniors in licensed residential care facilities, that require the operators of these facilities to report certain incidents, including abuse perpetrated by care aides and other employees. While this is important, our investigation identified gaps in this reporting system.

First, it is the operator who is required to report these incidents, not staff or other people in a facility who are aware of a case of abuse or neglect. It should be the responsibility of everyone who works with vulnerable seniors to protect them from abuse and neglect. Home support workers and staff in assisted living residences and residential care facilities are well positioned to notice problems of this nature. As a result, it is essential that health authorities ensure that these staff are trained to recognize the signs of abuse and neglect and that they are required to report any concerns.

Second, there are no clear guidelines for when health authorities should report incidents of abuse or neglect to the police. This means that health authorities may not be making appropriate decisions about when to report potentially criminal matters. Furthermore, it is unreasonable to expect families or residents to decide whether to report an instance of abuse or neglect to the police. If clear guidelines were in place, the health authorities would be able to decide when an incident warrants a police report. This would help ensure consistency in responding to incidents of abuse and neglect.

Lastly, although the director of licensing has issued a standard of practice to clarify the *Residential Care Regulation*, the definition of abuse in the Regulation excludes incidents where the aggressor is another resident. Abuse by a resident to another resident is still not treated in the same way as other reportable incidents under the Regulation.

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We identified a further gap in the system of protections for seniors in facilities governed by the *Hospital Act*. The *Hospital Act* does not include provisions that are equivalent to the “reportable incident” requirements in the *CCALA* and the Regulation. This means that residents of the province’s more than 100 facilities governed under the *Hospital Act* do not benefit from the same level of protection as residents of facilities licensed under the *CCALA*. While residents of *Hospital Act* licensed facilities are still covered by the *Adult Guardian Act*, the reporting provisions in the *Adult Guardian Act* are voluntary rather than mandatory. The ministry should take steps to address this gap by ensuring that mandatory reporting requirements equivalent to those found in the *CCALA* are created under the *Hospital Act*.

On a broader level, health authorities, facility operators, families, health care providers and seniors would be better informed and positioned to respond to the abuse and neglect of seniors if they had accurate and current information on the extent of the problem. While it is important to record incidents of abuse and neglect in individual client files, each of the health authorities also needs to track this information on a regional basis. This would help identify systemic problems and inform potential solutions.

The Ombudsperson finds that

- F23. The Ministry of Health does not require care staff to report information indicating seniors receiving home support, assisted living or residential care services are being abused or neglected.

The Ombudsperson recommends that

- R27. The Ministry of Health take the necessary steps to require staff providing care to seniors to report information indicating that a senior is being abused or neglected to the regional health authority.

The Ombudsperson finds that

- F24. The Ministry of Health does not require operators of facilities governed under the *Hospital Act* to report incidents of abuse and neglect of residents.

The Ombudsperson recommends that

- R28. The Ministry of Health take the necessary steps to require operators of residential facilities governed under the *Hospital Act* to report instances of abuse and neglect of residents.

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The Ombudsperson finds that

- F25. The health authorities do not track the number of reports of abuse and neglect they have investigated or the number of support and assistance plans they have implemented in response to investigations of abuse and neglect.

The Ombudsperson recommends that

- R29. The health authorities track the number of incidents of abuse and neglect investigated in their region and the number of support and assistance plans implemented in response to their investigations of these reports.

The Ombudsperson finds that

- F26. The Ministry of Health does not require service providers to notify the police of an incident of abuse or neglect that may constitute a criminal offence.

The Ombudsperson recommends that

- R30. The Ministry of Health require service providers to immediately notify the police of all incidents of abuse and neglect that may constitute a criminal offence.
- R31. The Ministry of Health work with the health authorities to develop provincial guidelines on when service providers should report incidents of abuse and neglect to the police.

Protecting Seniors in Care from Financial Abuse

Seniors who receive care from paid caregivers often form strong attachments to those people and may want to demonstrate their appreciation through gifts. Often these gifts are offered freely and without coercion, but this is not always the case. Since seniors in care are vulnerable to financial exploitation, it is important that they are protected from this form of abuse at the hands of their paid caregivers. Both the *Community Care and Assisted Living Act (CCALA)* and the *Hospital Act* provide some protection from financial abuse for residents of facilities that are governed by these acts.

Under the *CCALA*, facility operators and their employees must not induce or persuade a resident to give them something that would benefit either them or their relatives or friends. The Act makes doing so an offence for which a person can be fined up to \$10,000.¹²⁷ In addition, any gifts or changes to an adult's will that benefit a facility operator or a person working for the operator are void unless the public guardian and trustee has consented to them in writing.¹²⁸ Similar provisions exist in section 4.1 of the *Hospital Act*.¹²⁹

¹²⁷ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, s. 18(3) and s. 33.

¹²⁸ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, s. 18(4).

¹²⁹ *Hospital Act*, R.S.B.C. 1996, c. 200, s. 4.1. The *Hospital Act* provisions regarding financial abuse do not apply to those in acute care.

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No similar provisions apply to those in assisted living residences or to those receiving home support services. Given that seniors who are receiving care in their own homes may be even more vulnerable to financial abuse than those who receive more closely supervised care in regulated facilities, the rationale for this exclusion is not clear.

Table 6 – Protecting Seniors from Financial Abuse

	Home support	Assisted living	Residential care licensed under the <i>CCALA</i>	Residential care governed under the <i>Hospital Act</i>
Operator	No legislative protection from financial abuse by an operator	No legislative protection from financial abuse by an operator	Section 18(3) of the <i>CCALA</i> prohibits financial abuse by an operator	Section 4.1 of the <i>Hospital Act</i> prohibits financial abuse by an operator
Employee	No legislative protection from financial abuse by an employee	No legislative protection from financial abuse by an employee	Section 18(3) of the <i>CCALA</i> prohibits financial abuse by an employee	Section 4.1 of the <i>Hospital Act</i> prohibits financial abuse by an employee
Other resident	No legislative protection from financial abuse by another resident	No legislative protection from financial abuse by another resident	No legislative protection from financial abuse by another resident	No legislative protection from financial abuse by another resident

The Ombudsperson finds that

F27. The Ministry has not ensured that seniors who receive home support services or live in assisted living residences have the same legal protection from financial abuse as those who live in residential care facilities.

The Ombudsperson recommends that

R32. The Ministry of Health take the steps necessary to ensure that seniors who receive home support services or live in assisted living residences have the same level of legal protection from financial abuse as those who live in residential care facilities.

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Protecting Those Who Report Concerns

Persons in care rely on their caregivers for some or all of their most basic needs. Such people are vulnerable, and may be unable to report concerns due to physical or cognitive challenges, or may be unwilling to do so because they fear that services will be changed or interrupted. Friends and family members of a person in care may be able to complain on his or her behalf, but may not know that there is a problem, or might fear that complaining will result in a worse situation. Employees who provide care to seniors, especially those who provide front-line services, are well placed to observe problems and observe improvements. Ideally, staff feel free to report any concerns or issues they observe. However, in practice, some may be reluctant to speak up for fear of being viewed as a troublemaker or even of being fired. It is natural and predictable that employees will be less likely to raise concerns and issues when they fear that doing so could undermine their job security.

Any fear of retaliation, whether well founded or not, either against the person in care or against the person making the complaint, or against both, necessarily has a chilling effect on the reporting of concerns. It is critical that people feel secure in registering concerns, especially where the complaint involves abuse or neglect. Unfortunately, the current legislative framework provides a very incomplete set of protections for persons in care and other complainants. The scope and nature of protection varies depending on the type of services provided, the type of complaint, and who is making the complaint.

Adult Guardianship Act

Under the *Adult Guardianship Act (AGA)*, anyone who has information indicating that a vulnerable adult (of any age), who is unable to seek assistance is being abused or neglected, may report that information to one of the agencies designated by the public guardian and trustee. The designated agencies include all five regional health authorities, Providence Health Care Society and Community Living BC.¹³⁰ Section 44 of the Act states that the *AGA* is meant to provide support and assistance only to abused or neglected adults who cannot seek support for themselves due to a physical restraint, physical handicap that limits their ability to seek help, or a condition that affects their decision-making ability about the abuse or neglect. Neglect in the *AGA* is defined to include “self-neglect,” which means that action may be taken to seek support and assistance for an adult who is at risk due to the adult’s lack of care for his or her self. Under section 46 of the Act, the health authorities and the public guardian and trustee must keep the names of those who make such reports confidential. Furthermore, the *AGA* states that a person who makes a report must not be refused employment, threatened, discriminated against, intimidated, coerced, disciplined or penalized as a result of the complaint. Those who make such reports in good faith also cannot be held legally liable.¹³¹ These legal protections apply to the person making the complaint, though not to the person who is unable to complain, regardless of the setting in which the suspected abuse or neglect takes place.

The provisions of the *AGA* do not protect those who complain or raise concerns about issues other than abuse or neglect, such as complaints about service quality.

¹³⁰ *Adult Guardianship Act*, R.S.B.C. 1996, c. 6, s. 46(1).

¹³¹ *Adult Guardianship Act*, R.S.B.C. 1996, c. 6, s. 46(3) and (4).

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Community Care and Assisted Living Act

Licensed Residential Care

The *Community Care and Assisted Living Act (CCALA)* protects employees and agents of licensees who report instances of abuse that take place in residential care facilities licensed under that Act. Section 22 of the *CCALA* states that no action or other proceeding can be brought against a person for reporting abuse if the report is made in good faith. Residents of *CCALA* facilities are also protected by the provision that states that operators must not “alter, interrupt or discontinue” service or threaten to do so in response to a report of abuse or someone’s stated intention to report abuse.¹³²

The *Residential Care Regulation* that accompanies the *CCALA* also provides protection for a person in care in a residential care facility. Section 60 of the Regulation requires operators of residential care facilities to ensure that “there is no retaliation against a person in care as a result of anyone expressing a concern or making a complaint. ...”

In December 2009, the provincial government enacted the Residents’ Bill of Rights, which meant that residents in care were protected from the following consequences as a result of a complaint:

A licensee must not evict, discharge, intimidate, coerce, impose any pecuniary or other penalty on, suspend a service to, deny a right or benefit to or otherwise discriminate against a person in care because of a complaint made in relation to the person in care under [the *Community Care and Assisted Living Act*] or the *Patient Care Quality Review Board Act*.¹³³

However, the protections in the *Residential Care Regulation* and the Residents’ Bill of Rights do not extend to staff or other non-residents who complain and therefore do not protect a staff person who complains from such actions.

Assisted Living Residences

Although assisted living residences are governed by the *Community Care and Assisted Living Act (CCALA)*, the protection offered by section 22 for those who report abuse in *CCALA*-licensed residential care facilities does not apply to reports of abuse in assisted living residences. Therefore, assisted living employees, agents and others who report abuse are not provided the same legal protections if they report abuse in good faith, and assisted living residents are not legally protected under the *CCALA* from retaliatory action due to a report. Also, the protections provided to residential care residents by the *Residential Care Regulation* and the Residents’ Bill of Rights do not extend to assisted living residents.

¹³² *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, s. 22(3).

¹³³ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, Schedule (Residents’ Bill of Rights), s. 3.

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Hospital Act

The Residents' Bill of Rights extends protection to residents of residential care facilities governed under the *Hospital Act* who complain or are involved in a complaint made by a third party. However, unlike facilities licensed under the *CCALA*, the *Hospital Act* does not protect non-residents who make reports. This means that employees of facilities under the *Hospital Act* who report concerns are not protected.¹³⁴

Table 7 – Protecting Those Who Report Concerns

	Employee complaint or concern	Employee report of abuse or neglect	Client, resident complaint or concern	Client, resident report of abuse or neglect	Friend, family, other complaint	Friend, family, other report of abuse or neglect
Home support	No protection	s.46 AGA ¹	No protection	s.46 AGA	No protection	s.46 AGA
Assisted living	No protection	s.46 AGA	No protection	s.46 AGA	No protection	s.46 AGA
Residential care CCALA	No protection	s.46 AGA s.22 CCALA	s.60 Regulation ² Residents' Bill of Rights	s.46 AGA	No protection	s.46 AGA
Residential care Hospital Act	No protection	s.46 AGA	Residents' Bill of Rights	s.46 AGA	No protection	s.46 AGA

¹ Section 46 of the *Adult Guardianship Act* applies to reports of abuse and neglect where the adult is unable to seek help.

² *Residential Care Regulation*

¹³⁴ If an employee of a facility makes a report of abuse or neglect under section 46(2) of the *Adult Guardianship Act* that employee's identity is protected from disclosure by the health authority to anyone requesting information.

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Table 8 – Protecting Person in Care or Recipient of Service

Service Offered	Report of Abuse or Neglect	Complaint or Concern
Home support	No protection	No protection
Assisted living	No protection	No protection
Residential care (CCALA facility)	s.22 <i>CCALA</i> protects person in care from retaliation from complaint of abuse or neglect	Residents' Bill of Rights s.60 <i>Regulation</i> ¹
Residential care (Hospital Act facility)	No protection	Residents' Bill of Rights

¹ *Residential Care Regulation*

Analysis

The *Adult Guardianship Act* provides protection for those who report concerns about the abuse or neglect of adults including seniors who are receiving home support, assisted living or residential care services where the senior themselves is unable to seek action. The *CCALA* provides additional protection for anyone who reports abuse or neglect that takes place in a licensed residential care facility. However, these additional protections only apply in a residential care facility licensed under the *CCALA*. Staff of *Hospital Act* facilities do not receive the same protection. There are no legislated protections for employees or agents who raise a concern or complaint other than about abuse or neglect — about service quality, for example.

Residents who live in *CCALA*-licensed facilities are protected against adverse consequences for making complaints by the *Residential Care Regulations* and the Residents' Bill of Rights, while residents who live in residential care licensed under the *Hospital Act* receive the benefit of only the Residents' Bill of Rights. Seniors who receive home support or assisted living services are not protected from any such action that results from a complaint or concern being raised, whether about abuse or otherwise.

There is no legislative provision that applies to all people — residents, employees, and others — who raise any type of concern or complaint about home and community care services, and that protects both the person receiving services and the person making the complaint. This patchwork approach to legislated protections is highly problematic. Many people do not receive any sort of protection at all against what is, in essence, reprisals. Others may benefit from protection, but the varying levels and sources of protection make it difficult to be certain if someone will receive protection. This fear of retribution naturally means people will be less likely to report concerns.

By comparison, Ontario's *Long-Term Care Homes Act* contains extensive whistle-blower protections. The Act prohibits retaliation by one person against another for disclosing anything to an inspector or director. Retaliation includes:

- dismissing an employee
- disciplining or suspending an employee
- imposing a penalty on any person
- intimidating, coercing or harassing any person

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- discharging a resident [or] threatening to discharge a resident
- changing or discontinuing services.

Further, if an employee believes that an employer is retaliating as a result of information he or she provided, the employee can make a complaint to the Ontario Labour Relations Board. Operators in Ontario are also prohibited from discouraging reporting.

Similarly, Ontario's *Retirement Homes Act* requires any person who has reasonable grounds to suspect that a resident is:

- being improperly or incompetently treated
- being abused
- having their money misused or misappropriated
- otherwise being subject to other unlawful conduct

to immediately report their suspicion, and the grounds on which it is based, to the registrar. The Act prohibits anyone from discouraging reporting of abuse, protects against retaliation or discrimination arising from a complaint, and provides legal immunity for complaints made in good faith. Unproclaimed sections of the Act extend protection against retaliation to anyone who raises a concern of any sort, such as quality of care concerns, and the person in care.

Conclusion

The Ministry of Health has a responsibility to ensure that everyone who in good faith raises concerns or complaints about the care provided to seniors is protected. As well, seniors must be protected when others make complaints on their behalf. It is also necessary for the ministry to ensure that the health authorities actively monitor and enforce these protective mechanisms. Seniors' vulnerability must be mitigated by the legislation that governs home and community care services. Standardizing the protections that apply to complainants and persons in care who raise concerns and make complaints is a necessary and positive step.

The Ombudsperson finds that

F28. The Ministry of Health has not ensured that there is comprehensive legal protection from adverse consequences for anyone, including staff, who makes a complaint in good faith about home and community care services.

The Ombudsperson recommends that

R33. The Ministry of Health take the necessary steps to provide comprehensive legal protection from adverse consequences for anyone, including staff, who makes a complaint in good faith about home and community care services.



Home Support

Program Overview

Description of Services

- Home support workers, also referred to as community health workers, help seniors with daily activities such as getting up and around, getting dressed, using the bathroom, preparing meals and taking medications.
- Home support services are provided in seniors' homes, including private homes, independent housing and assisted living residences.
- Services are intended to help seniors (and others) who are still able to live independently in their homes and communities for as long as they can safely do so. They are meant to supplement the care that families and others provide.¹³⁵

Service Delivery

- Subsidized home support services are part of the home and community care program, which is overseen by the Ministry of Health and delivered by the health authorities.
- Subsidized services may be provided by employees of health authorities or by other organizations, either non-profit or for-profit, with which a health authority has made a contract.
- Seniors and their families can obtain funding from the government to hire and manage their own home support services, through the Choice in Supports for Independent Living Program, established as a pilot in 1994 and implemented province-wide in 1995.
- Seniors can also arrange to receive home support services directly from a private provider.¹³⁶

Number of Seniors Served

- In 2009/10, there were at least 24,724 seniors receiving subsidized long-term home support services in British Columbia.¹³⁷

Legislation

- Subsidized home support services are administered under the *Continuing Care Act*.¹³⁸
- The Act does not include specific standards for home support but does authorize the Minister of Health to issue "standards, guidelines or directives" that are binding on service providers.¹³⁹

¹³⁵ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Overview: Home and Community Care Services, 1.A.

¹³⁶ Individuals in British Columbia may choose to privately purchase various services that are similar in nature to subsidized home support services.

¹³⁷ Because of incomplete data submissions from the Interior Health Authority and the Vancouver Coastal Health Authority to the Ministry of Health for 2009/10, this measure may be understated.

¹³⁸ *Continuing Care Act*, R.S.B.C. 1996, c. 70.

¹³⁹ Section 4(4) of the Act states: "The Minister may issue standards, guidelines or directives and may issue different ones for different classes of operators or for different classes of health care services."

Home Support

Cost of Providing Services

- In 2009/10, the regional health authorities spent a total of approximately \$339 million providing subsidized home support services throughout British Columbia.
- It typically costs the health authorities \$30 to \$40 to provide each hour of subsidized home support.

Cost of Receiving Services

- Health authorities use a formula set by regulation to calculate how much subsidized home support clients will be charged. The formula is based on income tax information from the previous year. As a result of applying this formula:
 - approximately 71 per cent of home support clients pay nothing to receive these services
 - 3 per cent pay up to \$10 per day
 - 6 per cent pay between \$10 and \$20 per day
 - 20 per cent pay more than \$20 per day
 - seniors with earned income pay a maximum of \$300 per month for home support

Home Health Services

Subsidized home support services are part of the broader provincial home and community care program, which is overseen by the Ministry of Health and delivered by the health authorities and their contractors. Home support services are provided by home support workers and include support with tasks that seniors may have difficulty doing on their own, such as bathing, dressing, using the bathroom and taking medications. Many seniors are able to continue living in their own homes when they receive assistance with these basic tasks. In addition to these services, home support may include safety maintenance activities and specific nursing and rehabilitation tasks that have been delegated.¹⁴⁰ Seniors may also receive nursing and other medical tasks in their homes delegated to a community health worker by a health professional.

Currently, services such as housekeeping, grocery shopping and transportation are not generally available through the provincial home support program. However, as discussed in “Changes in Home Support Policy” later in this section, some of these services were included in the provincial home support program in the 1980s.

Home support is one of the home health services available through the health authorities. The Ministry of Health’s *Home and Community Care Policy Manual* describes the services available under the provincial home health program as follows. (In this report, we use the term “home support” to refer to what is described below as “home health services.”)

Adult day services are provided through an organized program in a group setting and may include personal care, health care and therapeutic social and recreational activities. Adult day services may be provided either to meet a senior’s health care needs and/or a caregiver’s need for respite.

¹⁴⁰ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Home Health Services: General Description and Definitions, 4.A.

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Community nursing services are health care services provided by a licensed nursing professional to clients who require acute, chronic, palliative or rehabilitative support.

Community rehabilitation services are health care services provided by a physical therapist or occupational therapist to clients who require acute, chronic, palliative or rehabilitative support.

Continuous home health services are services provided on a long-term basis (usually longer than three months) to either a client who is at significant risk of institutionalization due to unstable, chronic health conditions, and/or living conditions and/or personal resources or a client with stable, chronic health conditions, stable living conditions and personal resources who needs support in order to remain living at home.

Time-limited home health services are services provided on a short-term basis (usually less than three months) to a client who needs immediate or urgent time-limited interventions to improve or stabilize a medical or post-surgical condition, to a client for whom death is anticipated within six months or to a client with a stable health condition that is expected to improve with a time-limited focus on functional rehabilitation.¹⁴¹

According to the Ministry of Health, home support services are intended to:

- assist clients to live in their own homes as long as possible¹⁴²
- supplement, but not replace, the care provided by families, other unpaid caregivers and communities¹⁴³
- promote the independence and well-being of clients and their families¹⁴⁴
- provide respite care to the family member or other unpaid caregiver ordinarily caring for the person in the person's home¹⁴⁵

One of the stated purposes of home support is to provide services to people who would otherwise be admitted to a hospital, residential care facility or assisted living unit. The other purpose is preventive: it is meant to delay or prevent institutionalization or further deterioration of health. Home support workers are often in a good position to monitor any changes in their clients' health or functioning and to identify and address issues as they emerge. Home support services can therefore help to reduce or delay the need for more costly acute or residential care.

¹⁴¹ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Home Health Services: General Description and Definitions, 4.A.

¹⁴² Ministry of Health, "Community Care Services — Home Support" <<http://www.health.gov.bc.ca/hcc/homesupport.html>>.

¹⁴³ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Overview: Home and Community Care Services, 1.A.2.

¹⁴⁴ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Overview: Home and Community Care Services, 1.A.

¹⁴⁵ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Home Health Services: Home Support Services, 4.B.1.

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What We Heard

Since initiating this investigation, the Ombudsperson's office has received a variety of complaints about publicly subsidized home support services, including:

- reductions of home support hours
- the narrow range of available services
- the elimination of housekeeping services
- lack of continuity in home support workers
- scheduling of home support workers
- unclear complaints processes
- the inadequacy of available information

Many of the people who contacted us told us that restrictions on home support services contributed to either their or a family member's move into a facility sooner than they would have liked.

The following is an example of the concerns we heard during our investigation. (The names below have been changed to protect confidentiality.)

Paula and Grace's Story

Paula contacted us in 2008 because the number of home support hours available to her mother Grace had been unexpectedly reduced by approximately 50 per cent. Grace had been receiving 74 hours of home support per month (just over 2.5 hours per day) and relied on her home support workers to prepare her meals, do her laundry and give her regular baths.

Because Grace's health needs had not changed, she and Paula did not understand why her home support hours had been reduced by so much. The reduction meant that Grace had to rely on another relative, who was only temporarily available, to help her with cooking. Grace's sheets were no longer changed regularly, nor was she bathed as often as she believed was necessary to properly manage her skin condition. When Paula complained to the Fraser Health Authority, staff there said Grace would have to pay privately for the services formerly included in her care plan. Grace began to worry that she would not be able to pay for private home support and so would have to move into a residential care facility sooner than would otherwise be necessary.

During our investigation of Paula's complaint, Fraser Health explained that Grace's hours had been reduced because the local home support agency believed her needs could be met in half-hour rather than one-hour blocks. The home support agency had relayed this information to the health authority's case manager, who conducted a reassessment at Grace's home and reduced Grace's approved hours. Health authority staff told us that they had approved the reduction because they believed that the same number of tasks could be performed in less time. However, Grace reported that her case manager had told her that the reduction was part of an overall service cutback.

Paula and her mother were concerned about how Fraser Health had treated them. They had been given conflicting reasons for the change in service and were not told that they could complain to the health authority about the reduction or ask to have it reviewed. In the course of our investigation, Fraser Health considered Grace's needs again and decided to restore most of her home support hours. Fraser Health staff also acknowledged that the half-hour blocks did not provide enough time to complete the necessary tasks.

The future effectiveness of the home and community care system requires a fundamental shift from a system that invests the majority of its resources in acute and residential care services to one that maintains individuals in their homes for as long as is desirable. This requires redesigning the current system to one that provides a broader range of home based services to a greater number of people.

Source: Ministry of Health Services,
Transforming Home and Community Care,
2002.

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Changes in Home Support Policy

Provincial policy on access to home support and on the range of services available under the home support program has changed over the past 30 years. In the course of our investigation, many of the seniors, family members, advocates, service providers and health care workers we spoke to told us that they believed the home support program would be more effective if it provided, as it once did, a broader range of services to people with chronic conditions as well as to seniors who require some assistance in order to maintain their independence. This section examines the key changes in the provincial home support program starting in the 1980s.

Clients will be able to access, from their homes, an array of innovative services responsive to their unique needs and conditions and have access to consumer information and education promoting health and well-being.

Source: Ministry of Health Services, *Transforming Home and Community Care*, 2002.

British Columbia has had a home support program since the 1950s, though it has had different names over the years. The program was initially administered by the provincial Department of Rehabilitation and Social Improvement, which provided services to those with low incomes. The provincial government recognized home support as a health program in 1978.

Home Support in the 1980s

In the 1980s, the goal of the program was “to provide personal assistance with activities of daily living and/or essential household tasks which the client was unable to perform independently.”¹⁴⁶ In 1983, the ministry’s policy stated that home support workers (then referred to as homemakers) were responsible for:

- performing, demonstrating and teaching accepted methods of household cleaning, and working with individuals and families to establish and maintain a wholesome atmosphere in the home
- demonstrating and teaching nutritional concepts, planning menus, purchasing food and preparing and serving meals, including those that were part of special diets
- providing personal assistance, including hair washing, shaving, dressing, oral hygiene, washing, bathing, toileting, assisting in walking with or without mechanical aid, assisting in feeding, taking temperature, transferring, assisting with nail care, making beds, assisting in maintaining healthy skin, assisting clients who are responsible for their own medication, assisting with prostheses, applying general first aid and assisting sick clients¹⁴⁷

Ministry policy at that time allowed help with shopping and home maintenance tasks, such as garbage and snow removal and chopping firewood, to be authorized on an exceptional basis.¹⁴⁸ The maximum number of home support hours that could be approved was based on each person’s assessed level of need, but managers

¹⁴⁶ Canadian Centre for Policy Alternatives, *From Support to Isolation: The High Cost of BC’s Declining Home Support Services*, June 2006, 15.

¹⁴⁷ A homemaker was defined as “an employee who works in the homes of individuals within the community to maintain a supportive environment and to provide assistance with the activities of daily living.” Ministry of Health and Ministry Responsible for Seniors, *Service Provider Policy Handbook*, December 1983, Home Support Services: Homemaker Agency, 5.A.

¹⁴⁸ Ministry of Health and Ministry Responsible for Seniors, *Service Provider Policy Handbook*, December 1987, Home Support Services: Homemaker Agency, 5.A.

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could authorize extensions.¹⁴⁹ In some cases, live-in services were available for people who required 24-hour service. When a person had to travel to another community within the province for medical, educational, work or vacation purposes, homemakers' hours could be extended to allow them to accompany clients, provided certain eligibility criteria were met.¹⁵⁰

Home Support in the 1990s

In 1991, British Columbia's Royal Commission on Health Care and Costs (the Seaton Commission) recommended transferring resources from hospitals to the community in order to prevent unnecessary hospital and residential care admissions.

However, in 1992, the provincial government began to make changes to home support policies. Significant changes made included elimination of meal preparation, transportation and housekeeping services that had been included in the program.¹⁵¹

In the mid-1990s, the federal government cut health care transfers to the provinces, which affected British Columbia's home and community care program.¹⁵² The mid-1990s also marked the beginning of regionalization of health care services, with responsibility for these services transferred to 52 different health boards in 1997.

In 1994, the Choice in Supports for Independent Living (CSIL) program was created as a pilot project and became available province-wide in 1995. The new policy required regional health boards to fund self-managed home support services for people who had the ability to direct all aspects of their care or who had a client support group to do so on their behalf. Funding was provided directly to clients (or their support group), who were made responsible for the hiring, scheduling and supervising of their home support workers.

Royal Commission on Health Care and Costs

British Columbia's inquiry into health care in the early 1990s stressed the importance of moving health care services "closer to home," particularly for seniors.

The report stated that "health care services and programs for seniors and the frail elderly should be characterized by the maximum degree of autonomy [and] a continuum of care including the home, the community and, if necessary, institutions."

The commission's final report clearly preferred options to keep people in their own homes for as long as possible.

Source: *Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs*, 1991, A-8.

¹⁴⁹ The maximum hours of service were 40 hours/month for personal care, 46 hours/month for intermediate level I, 64 hours/month for intermediate level II, 98 hours/month for intermediate level III and 120 hours/month for extended care.

¹⁵⁰ Ministry of Health and Ministry Responsible for Seniors, *Service Provider Policy Handbook*, December 1983, Home Support Services: Homemaker Agency, 5.A.

¹⁵¹ Ministry of Health Services, "Home Support," fact sheet, 2008.

¹⁵² K.M. McGrail et al., Centre for Health Services and Policy Research, University of British Columbia, *Home Health Services in British Columbia: A Portrait of Users and Trends Over Time*, October 2008, 16.

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In 1999, the provincial government revised the provincial home support policy. Home support services were then to:

- help people live in their own homes for as long as it is practical and in their and their family's best interests
- supplement, but not replace, the care provided by families, other unpaid caregivers and communities
- promote the independence and well-being of clients, their families and other unpaid caregivers provide respite care to the family member or other unpaid caregiver ordinarily caring for the person in the person's home¹⁵³

The provincial government's 1999 revised policy indicated that home support services were provided only to those individuals "who would otherwise be institutionalized ... and on a preventive basis to clients at high risk of institutionalization or of further deterioration in functional or health status."¹⁵⁴ The available home support services were personal assistance, which included bathing, grooming, meal preparation, help with using the toilet and moving around, and, when appropriate, housekeeping, which included cleaning, laundry, transportation, banking and shopping. Housekeeping could only be provided as a stand-alone service on an exceptional basis. Home support services were to be provided on the basis of assessed needs, with the highest levels of need given priority.

The 1999 policy also marked the first significant shift toward reliance on community-based programs. The policy indicated that the 52 health authorities that existed at the time were expected to work collaboratively with community stakeholders in the planning, operation and coordination of voluntary community services, such as grocery shopping, home maintenance, hospice care and transportation.

Home Support in the 2000s

In 2000, the provincial government more clearly defined eligibility for home support. At that time, in order to qualify for services, individuals were required to:

- be a Canadian citizen or permanent resident, with residency in British Columbia, or a refugee or someone holding a Minister's Permit¹⁵⁵
- be 19 years of age or older (with exceptions for those under 19 in residential care or admitted to mental health boarding homes)¹⁵⁶

"My mother received home support from 2002 to 2005 and is presently in a nursing home. Home support was limited to personal care. If she could have had help with laundry and cooking, she would have stayed in her own apartment instead of moving into the home."

Source: Respondent, Ombudsperson's questionnaire.

¹⁵³ Ministry of Health and Ministry Responsible for Seniors, *Service Provider Policy Handbook*, November 1999, Community Support Services: Home Support, 5.A.1.

¹⁵⁴ Ministry of Health and Ministry Responsible for Seniors, *Service Provider Policy Handbook*, November 1999, Community Support Services: Home Support, 5.A.1.

¹⁵⁵ Ministry of Health, *Home and Community Care Policy Manual*, June 1989 and March 1992, Client Access: Eligibility, 2.A.

¹⁵⁶ Ministry of Health, *Home and Community Care Policy Manual*, March 1985, Client Access: Eligibility, 2.A.

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and

- be unable to live independently because of ongoing health-related problems of at least three months in duration that are due to a progressive and/or chronic condition¹⁵⁷
- be assessed as requiring home support services

and

- pay the client rate for home support¹⁵⁸

In December 2001, the provincial government consolidated 52 regional health boards into five regional health authorities. In 2002, the provincial government and health authorities announced that the home and community care program would be redesigned over the next three years. The stated purpose of doing so was, in part, to address the need for a broader range of care options and to avoid the unnecessary institutionalization of seniors by expanding the home support program and creating the assisted living program.¹⁵⁹

Premier's Council on Aging and Seniors' Issues

In its February 8, 2005, Throne Speech, the provincial government said it would establish a council that would include representatives from key seniors' organizations, every region and multicultural communities to "examine how to improve the full spectrum of seniors' housing options and homecare" and to "recommend comprehensive plans for reform."¹⁶⁰ The government established the Premier's Council on Aging and Seniors' Issues in October 2005 and tasked it with identifying how society can support the participation, health and well-being of older people in British Columbia.

The council issued its report and recommendations to government in November 2006. The report said that "the support services currently available to older British Columbians in their communities fall well short of meeting the needs of some older people," and urged the government to "bring vital services, such as a broader range of home support, to older people's homes and neighbourhoods to enable continued independence and a good quality of life."¹⁶¹

Supported by research indicating that the costs of expanding home support would be offset by long-term savings, especially in the areas of acute and long-term care, the council called for a "new vision for home support — one focused on prevention, maintaining quality of life, and avoiding the high cost — financial

¹⁵⁷ Ministry of Health, *Home and Community Care Policy Manual*, September 1986, Client Access: Eligibility, 2.A.

¹⁵⁸ Ministry of Health, *Home and Community Care Policy Manual*, May 2000, Community Support Services: Home Support, 5.A.1.

¹⁵⁹ Ministry of Health Services, "Home and Community Care Redesign," fact sheet, 4 February 2008.

¹⁶⁰ Speech from the Throne, Opening of the Sixth Session, 37th Parliament of the Province of British Columbia, 8 February 2005.

¹⁶¹ Premier's Council on Aging and Seniors' Issues, *Aging Well in British Columbia*, 2006, iii
<http://www.gov.bc.ca/seniors/documents/pdf/aging_well_in_BC.pdf>.

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and human — of institutional care.”¹⁶² A cost-benefit analysis conducted by a researcher and co-director of the National Evaluation of the Cost-Effectiveness of Home Care research project was considered by the council who found that:

After three years, people whose home support services were cut during the mid to late 1990s ended up costing our health system 52 per cent more than those who continued to receive support services in their homes. An average of \$7,807.96 in healthcare costs per person in the third year was found for those whose services were not cut, whereas the average was \$11,903.38 per person for those whose services were cut, a difference of \$4,095.42 per person.¹⁶³

The reason provided for the increase in costs was that those who lost home support services spent more time in hospitals and were likely to require either residential care or increased home support services. The council recommended that:

The B.C. government introduce a new broader and more widely available home support system by providing a wider range of home support services, including cleaning and home maintenance (culturally specific where appropriate, such as with meal preparation) to people who are unable to carry out these tasks on their own.¹⁶⁴

The council also recommended that home support be made available to people with lower care needs, as a preventive measure.¹⁶⁵ The council was concerned that the need for a broader home support program would get lost among the competing priorities of the Ministry of Health and so suggested that the government review whether responsibility for non-medical home support should remain within the health system or be transferred to another part of government.¹⁶⁶

Progress

In 2002, the provincial government introduced a policy change that allowed, in limited circumstances, CSIL clients or client support groups to pay some family members to provide home support services. This policy was expanded in 2007.¹⁶⁷

In September 2008, the newly created Ministry of Healthy Living and Sport produced *Seniors in British Columbia: A Healthy Living Framework*. The government created the Seniors' Healthy Living Secretariat within the ministry to support the implementation of the framework.¹⁶⁸ The government made this new organization responsible for developing models for non-medical home support services, saying,

¹⁶² Premier's Council on Aging and Seniors' Issues, *Aging Well in British Columbia*, 2006, iii <http://www.gov.bc.ca/seniors/documents/pdf/aging_well_in_BC.pdf>.

¹⁶³ Premier's Council on Aging and Seniors' Issues, *Aging Well in British Columbia*, 2006, 51.

¹⁶⁴ Premier's Council on Aging and Seniors' Issues, *Aging Well in British Columbia*, 2006, 56.

¹⁶⁵ Premier's Council on Aging and Seniors' Issues, *Aging Well in British Columbia*, 2006, 52.

¹⁶⁶ Premier's Council on Aging and Seniors' Issues, *Aging Well in British Columbia*, 2006, 53.

¹⁶⁷ Ministry of Health, *Home and Community Care Policy Manual*, April 2007, Community Support Services: Home Support, 5.A.4. In the current manual (April 2011), see Home Health Services: Home Support Services, 4.B.

¹⁶⁸ In a government reorganization announced on October 25, 2010, the Ministry of Healthy Living and Sport was dismantled and the Ministry of Health Services (now the Ministry of Health) became responsible for the Seniors' Healthy Living Secretariat.

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“We know that help with simple tasks such as housekeeping and yard work can make an enormous difference in helping older people remain in their own homes and communities.”¹⁶⁹

In 2011, the Seniors’ Healthy Living Secretariat consists of 16 people: an executive director, two directors, three managers and ten staff. Its role includes overseeing implementation of the Seniors’ Healthy Living Framework, building on programs that support seniors, ensuring that information on programs is easy to find, and establishing partnerships with local government, business and community organizations.

Since its establishment in September 2008, the Seniors’ Healthy Living Secretariat has been working with the United Way of the Lower Mainland to create a pilot program called Community Action for Seniors’ Independence (CASI).¹⁷⁰ CASI began with projects in five communities across the province: Dawson Creek, Maple Ridge, Osoyoos, Surrey (Newton) and Vancouver (Renfrew-Collingwood). Each project was expected to run for 18 months and to work with local non-profit societies, seniors’ groups, health authorities and businesses to develop models for providing non-medical home support. The secretariat anticipated that a mix of volunteers and paid staff would provide most of the home support services. Maple Ridge was the first community to launch the services phase of its pilot project, on July 5, 2010. The five pilot projects are expected to be completed by May 2012. The Ministry of Health reported that in collaboration with the United Way, an additional year of operational funding will be made available in the five communities based on a performance review. There is currently no provincial commitment to the CASI program beyond this.

The Seniors’ Healthy Living Secretariat will:

- Lead government’s implementation of the Seniors’ Healthy Living Framework, and monitor and evaluate progress.
- Explore innovative and sustainable models to provide non-medical home support services.
- Launch a one-stop, integrated information source on government programs and services for older people.
- Work and/or consult with the Multicultural Advisory Council and the Joint Federal-Provincial Immigration Advisory Council to ensure that older people from immigrant and ethno-cultural communities can access the information and services they need.
- Establish a provincial Seniors’ Healthy Living Network to engage citizens and stakeholders.
- Support opportunities to engage Aboriginal Elders in program and policy development.
- Promote public education on age discrimination.
- Encourage and support people to plan and save for retirement.

Source: *Seniors in British Columbia: A Healthy Living Framework*, 2008, 28.

¹⁶⁹ Ministry of Healthy Living and Sport, *Seniors in British Columbia: A Healthy Living Framework*, September 2008, 5.

¹⁷⁰ For the first three years of the CASI project (2009/10 - 2011/12), the United Way of the Lower Mainland contributed 26 per cent, 12 per cent and 15 per cent of the funding respectively, with the Ministry of Health contributing the remainder of the funding for the project.

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As of November 2011, a total of 738 seniors were registered to receive non-medical home support services through the CASI program and 562 had received services the most common services being transportation to medical appointments and shopping, housekeeping and friendly visiting. Other services provided included snow shovelling, yardwork, home maintenance and information/referral services.¹⁷¹

To be eligible for CASI services a client must be a resident of the community, must be age 65 or older and have a self-reported need for service. CASI services are available to seniors with a range of care needs, including those with lower care needs who are not currently receiving home support services through the health authority. Seniors' needs are assessed through an intake process at the lead agency either by phone, at the agency or at the senior's home.

Because the purpose of the CASI pilot project is to test different community-based models, the lead agency in each pilot community decides whether clients will be charged a fee for a particular service and the basis for that fee. The ministry reported that models range from charging no fee for a service, to requesting a donation, to using a sliding-scale fee schedule for services based on a the client's income.

Our investigation revealed the following barriers to effective implementation of the CASI non-medical home support model:

- **Service integration:** The secretariat has not given significant attention to the interaction between non-medical home support services and existing home support services provided through the health authorities in order to ensure continuity of care and minimize the number of different workers who provide services in a senior's home.
- **Complaints:** The secretariat has not considered whether the proposed CASI model will include a complaints or appeals process. The secretariat indicated that non-medical home support provided under the CASI program would not be considered a government program or a program provided by contractors. This means that people who receive CASI services would not be able to access complaints processes available through the regional patient care quality offices and review boards.
- **Volunteer training and screening:** The ministry informed us that, as of November 2011, all CASI volunteers and staff had been required to undergo a criminal record check. The standards for hiring qualified staff are up to the agencies providing the services.

While originally the emphasis of the CASI model was on volunteers, the pilot projects have confirmed that there is a need for care to be provided by paid caregivers in addition to volunteers.¹⁷²

¹⁷¹ CASI pilots were launched as follows: Maple Ridge — July 2010; Dawson Creek — October 2010; Osoyoos — November 2010; Surrey — November 2010; Vancouver — November 2010. Of the 562 seniors who received CASI services, 179 lived in Maple Ridge, 176 in Vancouver (Renfrew-Collingwood), 72 in Osoyoos, 51 in Dawson Creek, and 84 in Surrey (Newton).

¹⁷² The Ministry of Health informed us in December 2011 that there were 13 paid staff in the 5 lead agencies working on the CASI project and approximately 70 to 80 volunteers. The ministry stated there are additional paid service providers not on salary with the lead agencies.

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2011 Revisions to the Home and Community Care Policy Manual

Following the release of the *Best of Care: Getting It Right for Seniors in British Columbia (Part 1)* and while our investigation was being completed, the Ministry of Health released a revised version of the *Home and Community Care Policy Manual*. The revised policy eliminated the requirement that an individual's health problems be of at least three months' duration to qualify for subsidized home support services.¹⁷³ In addition to the option of establishing a client group to manage their care, Choice in Supports for Independent Living (CSIL) clients may now also designate a representative who is able to direct their home care using a valid representation agreement.¹⁷⁴ Effective April 1, 2011, the minimum funding provided to CSIL clients is \$27.63 per hour, which is an increase of \$2.00 per hour.¹⁷⁵

Other Models

While it may be necessary to find and create new ways of delivering non-medical home support, it is also useful to learn from existing models. The Premier's Council on Aging and Seniors' Issues noted that the Veterans Independence Program, run by the federal Department of Veterans Affairs, is designed to supplement provincial and regional programs that may not fully meet veterans' needs. The program provides eligible veterans with additional services, such as expanded personal care, meal assistance, housekeeping, transportation and outdoor maintenance, including grass-cutting and snow removal. This is a model that more closely reflects the recommendations of the premier's council. Other services that can be available to veterans under this program include adult day care, transportation costs for activities such as shopping, banking and visiting friends, and home adaptations for bathrooms and kitchens.

Across Canada, at least nine provinces and territories include housekeeping services (also known as homemaking, household management or domestic help services) as part of their home support program. For example, in Manitoba, home support services are funded through Manitoba Home Care and include assistance with meal preparation, housekeeping and laundry.¹⁷⁶ In Quebec, domestic help services include housekeeping, meal preparation, shopping

"We started with home support, which was wonderful. Mom was still at home and almost as independent as always. As her condition progressed (Alzheimer's), we could no longer afford the amount of home support required. I was quite shocked to discover that the government will support her living in a senior's home, but would not allot the same amount of monies to keep her comfortable at home. ... In hindsight, having witnessed first-hand what the loss of independence, personal property and privacy has done to my mother, I would have abandoned my job and kept her at home at ALL costs."

Source: Respondent, Ombudsperson's questionnaire.

¹⁷³ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Eligibility, 2.B.

¹⁷⁴ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Home Health Services: Choice in Supports for Independent Living (CSIL), 4.C.1.

¹⁷⁵ Ministry of Health, "B.C. to Boost Home Support Program Rates," news release, 28 March 2011.

¹⁷⁶ Canadian Home Care Association, *Portraits of Home Care 2008*, March 2008, 69.

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and laundry.¹⁷⁷ In the Northwest Territories, available home care services include home management, general upkeep and maintenance work, all funded through the Northwest Territories Coordinated Home Care Program.¹⁷⁸

Farther afield, Denmark has been widely recognized as an international leader in the development of home support services for seniors. Danish seniors have access to 24-hour home support services on the basis of need, free of charge. The Danish home support program includes help with cleaning and shopping, as well as basic home support services. Since the 1980s, Denmark has dramatically increased the availability of home support and home care services, while at the same time downsizing the institutional care sector.

In 1998, the Danish government moved to a preventive approach. It passed legislation requiring all municipalities to proactively offer home visits once a year to all citizens 75 and older.¹⁷⁹ These annual visits are meant to inform seniors about the services available to them and to ensure that municipal authorities, who are required to provide and administer the services, are aware of people whose needs are not being met.

Analysis

In 2005, the provincial government set as one of its “five great goals for the decade ahead” the task of building “the best system of support in Canada for persons with disabilities, special needs, children at risk and seniors.”¹⁸⁰

The government appointed the Premier’s Council on Aging and Seniors’ Issues and asked it to provide recommendations on how to build the best support system for seniors. In 2006, the council recommended, based on a cost-benefit

“Governments reduce funding for long-term home support services in the community (because they are not perceived to be “real health services”). People living in the community find it difficult to maintain their independence due to cuts to supportive services and are thus admitted to residential care or hospital. This, in turn, leads to greater cost pressures on hospitals, and the same cycle of using more costly service (i.e., hospital beds) to substitute for less costly services (home support) is repeated, over and over again, resulting in an ongoing spiral of increasing costs. What most people do not appear to grasp is the conundrum that while older adults and people with disabilities have legitimate medical needs (i.e., they have medical diagnoses), the most appropriate response, in large part, is to provide supportive services that allow these people to function as independently as possible for as long as possible.”

Source: Neena L. Chappell and Marcus J. Hollander, “An Evidence-Based Policy Prescription for an Aging Population,” *Healthcare Papers*, 2011, 11(1): 8-18.

¹⁷⁷ Canadian Home Care Association, *Portraits of Home Care 2008*, March 2008, 108.

¹⁷⁸ Canadian Home Care Association, *Portraits of Home Care 2008*, March 2008, 206.

¹⁷⁹ T. Rostgaard, SFI — The Danish National Centre for Social Research, “Danish Elder Care: Home Help and the Approach of Preventive Interventions” presented February 22-23, 2011, 10. 2011 Health Policy Conference, Vancouver, B.C. — <<http://www.chspr.ubc.ca/files/conference/2011/Slides/TineRostgaardBoomerangstfolder.pdf>>

¹⁸⁰ Speech from the Throne, Opening of the Sixth Session, 37th Parliament of the Province of British Columbia, 8 February 2005.

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analysis, that the provincial government introduce and fund a broad new home support system and make it available to people with lower care needs. However, rather than acting on this advice, the provincial government has focused on one of the council's other recommendations, which was to support volunteerism. The government made the Seniors' Healthy Living Secretariat responsible for developing models to provide non-medical home support services to seniors. The Secretariat partnered with the United Way and initiated pilot projects with the aim of providing non-medical home support services by volunteers. However, the pilot projects confirmed that there is a need for care to be provided by paid caregivers in addition to volunteers.

British Columbia's home support program provided a much wider range of services in the 1980s than it does now. Other models of home support, both nationally and internationally, make a broader range of non-medical services available to seniors with less acute needs, some free of charge. Although the Seniors' Healthy Living Secretariat has been working in this area, there has not been any large-scale expansion and reforms that would be required for the government to achieve its goal of having the "best system of support in Canada for seniors." It is particularly significant that the CASI model, the only home support initiative that has come out of the Premier's Council on Aging report, is identified by the government as "not a government program."

While the objective of the provincial home support program is clear — to assist clients to live in their own homes as long as it is practical and in the best interests of them and their families — the reality is that current limitations on services mean that seniors may not receive the support they need to do that. Since most seniors want to remain in their own homes as long as this remains a safe and viable option, it seems that making a broader range of home support services available would help achieve this objective. Since providing home support usually costs much less than providing care in an assisted living or residential care setting, it would also seem to make fiscal sense to expand the home support program.

The Ombudsperson finds that

F29. The Ministry of Health has not analyzed whether the home support program is meeting its goal of assisting seniors to live in their own homes as long as it is practical and in their and their families' best interests.

The Ombudsperson recommends that

R34. The Ministry of Health:

- analyze whether the current home support program is meeting its goal of assisting seniors to live in their own homes as long as it is practical and in their and their families' best interests, and make any necessary changes
- evaluate the home support eligibility criteria to ensure that they are consistent with program goals and make any necessary changes
- analyze the benefits and costs of expanding the home support program up to the cost of providing subsidized residential care when it is safe and appropriate to do so
- report publicly on the results of this analysis and evaluation by October 2013

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The Number of Seniors Supported

In 2010, there were approximately 677,770 seniors in British Columbia.¹⁸¹ The provincial population of seniors has grown by nearly 20 per cent since 2002.¹⁸² The number of seniors over 75 rose 18 per cent in the period July 1, 2002, to July 1, 2008.¹⁸³ Given this steady growth and the government's goal of supporting seniors to live independently for as long as possible, it seemed likely that the number of people receiving home support services would steadily increase. But as illustrated in the following table, this has not been the case.

Unfortunately, only the Fraser Health Authority could provide complete data on the number of seniors who received home support services during the period 2002/03 through 2009/10.¹⁸⁴ Therefore, our analysis is based on the information provided to our office by the Ministry of Health. According to the ministry staff, the data they received from the Interior Health Authority and the Vancouver Coastal Health Authority might be understated because the 2008/09 and 2009/10 data submissions from those health authorities were incomplete. The incomplete data submissions appear to be a result of problems transitioning from the Continuing Care Information Management System to the ministry's new Minimum Reporting Requirements system. As a result, there are no reliable provincial home support data for 2008/09 and 2009/10. The analysis that follows is based on the data provided by the ministry, which includes provincial data from 2002/03 through 2007/08, and on complete data provided by the ministry for the Fraser, Northern and Vancouver Island health authorities for 2002/03 to 2009/10. These gaps highlight the importance of having information management systems that are reliable.

¹⁸¹ BC Stats, "Population Estimates — Standard Age Groups"

<<http://www.bcstats.gov.bc.ca/data/pop/pop/dynamic/ProvPop/Query.asp?category=Prov&type=1&topic=Estimates>>.

¹⁸² There were 548,907 people over 65 on 1 July 2002, and 656,335 on 1 July 2009. BC Stats, "Population Estimates — Standard Age Groups"

<<http://www.bcstats.gov.bc.ca/data/pop/pop/dynamic/ProvPop/Query.asp?category=Prov&type=1&topic=Estimates>>.

¹⁸³ BC Stats, "Population Estimates — Standard Age Groups"

<<http://www.bcstats.gov.bc.ca/data/pop/pop/dynamic/ProvPop/Query.asp?category=Prov&type=1&topic=Estimates>>.

¹⁸⁴ The Vancouver Coastal Health Authority could only provide us with information about all long-term home support clients, not seniors specifically. The Interior Health Authority and Vancouver Island Health Authority had information for some of the years. The Northern Health Authority referred us to the Ministry of Health for information for all of the years.

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Table 9 – Seniors Receiving Subsidized Long-Term Home Support Services, Including Choice in Supports for Independent Living (CSIL), 2002/03 to 2010/11¹

Health authority*	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11 ²
FHA	8,095	7,991	7,725	7,403	8,216	9,671	9,435	8,599	Not available
IHA ³	5,146	5,157	5,069	6,503	6,240	6,139	5,929	4,695	Not available
NHA	1,426	1,031	1,007	1,001	899	892	881	813	Not available
VCHA ⁴	7,964	6,862	6,085	6,173	6,525	5,784	4,581	3,200	Not available
VIHA	6,508	6,618	6,590	6,753	7,274	7,874	8,294	7,417	Not available
Provincial total⁵	29,139	27,659	26,476	27,833	29,154	30,360	29,120	24,724	Not available

* Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

¹ Data provided by the Ministry of Health.

² The ministry informed us that due to IHA, NHA, VCHA data quality issues, the health authorities delayed submitting 2010/11 data to the ministry. Therefore, the ministry was unable to provide this information.

³ Because of incomplete data submissions to the Ministry of Health by IHA for 2008/09 and 2009/10, some measures may be understated.

⁴ Because of incomplete data submissions to the Ministry of Health by VCHA for 2008/09 and 2009/10, some measures may be understated.

⁵ Because of incomplete data submissions to the Ministry of Health by IHA and VCHA for 2008/09 and 2009/10, some measures may be understated.

The overall number of seniors in British Columbia who received subsidized home support services increased from 29,139 in 2002/03 to 30,360 in 2007/08, the only years for which we have complete data. This is an increase of 1,221 seniors (4 per cent). Since 2007/08, it appears, on the information provided, that the number of seniors receiving home support has been dropping.

The total number of seniors who received subsidized home support from Fraser Health increased from 8,095 in 2002/03 to 8,599 in 2009/10, an increase of 504 (6 per cent). However, between 2008/09 and 2009/10, the number dropped by 836 (9 per cent).

The number of seniors receiving subsidized home support from Northern Health has been steadily declining, with 534 (37 per cent) fewer seniors receiving services in 2007/08 than in 2002/03. The total number of seniors who received home support declined every year between 2002/03 and 2009/10, and 613 (43 per cent) fewer seniors were receiving home support in 2009/10 than in 2002/03. Between 2008/09 and 2009/10, the number of seniors receiving home support dropped by 68 (8 per cent). Northern Health explained that while the number of seniors receiving subsidized home support services has been steadily declining, there is an increase of high level complex care clients included in this group.

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The number of seniors receiving subsidized long-term home support services from VIHA has generally increased since 2002/03. The number of seniors receiving home support from VIHA peaked in 2008/09, with 1,786 (27 per cent) more seniors receiving services than in 2002/03. The number of seniors receiving services declined by 877 (11 per cent) in 2009/10. Despite this recent decline, VIHA still provided service to 909 (14 per cent) more seniors in 2009/10 than in 2002/03.

The number of seniors who received subsidized long-term home support services from Interior Health between 2002/03 and 2007/08 increased by 993 (19 per cent).

The number of seniors who received subsidized home support services from Vancouver Coastal Health has declined markedly since 2002/03. In 2002/03, there were 7,964 seniors receiving services, compared with 5,784 seniors in 2007/08, a difference of 2,180 (27 per cent).

As this analysis indicates, there is a significant variation between health authorities in whether the number of seniors receiving home support services is increasing or decreasing.

Between 2002/03 and 2007/08, seniors consistently accounted for about 84 per cent of long-term home support clients. However, the long-term home support hours provided to seniors between 2002/03 and 2009/10 made up only about 69 per cent of the total hours provided to all long-term home support clients throughout the province.

Table 10 – Hours of Subsidized Long-Term Home Support Services, Including Choice in Supports for Independent Living (CSIL), Provided to Seniors, 2002/03 to 2010/11¹

Health authority*	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11 ²
FHA	1,539,974	1,532,040	1,554,454	1,574,908	1,660,308	1,777,183	1,768,539	1,659,312	Not available
IHA ³	772,634	863,976	893,582	1,012,777	947,981	919,999	882,283	582,632	Not available
NHA	218,267	198,754	227,114	227,786	194,736	160,482	179,584	149,414	Not available
VCHA ⁴	1,474,227	1,278,509	1,179,428	1,305,827	1,346,345	1,251,986	1,171,855	495,791	Not available
VIHA	1,363,089	1,461,253	1,456,489	1,515,458	1,712,678	1,838,435	1,907,384	1,843,526	Not available
Provincial total ⁵	5,368,191	5,334,532	5,311,067	5,636,756	5,862,048	5,948,085	5,909,645	4,730,675	Not available

* Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

¹ Data provided by the Ministry of Health.

² The ministry informed us that due to IHA, NHA, VCHA data quality issues, the health authorities delayed submitting 2010/11 data to the ministry. Therefore the ministry was unable to provide this information.

³ Because of incomplete data submissions to the Ministry of Health by IHA for 2008/09 and 2009/10, some measures may be understated.

⁴ Because of incomplete data submissions to the Ministry of Health by VCHA for 2008/09 and 2009/10, some measures may be understated.

⁵ Because of incomplete data submissions to the Ministry of Health by IHA and VCHA for 2008/09 and 2009/10, some provincial measures may be understated.

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The total number of hours of home support services provided to seniors rose from 5,368,191 in 2002/03 to 5,948,085 in 2007/08, an increase of 579,894 hours (11 per cent).

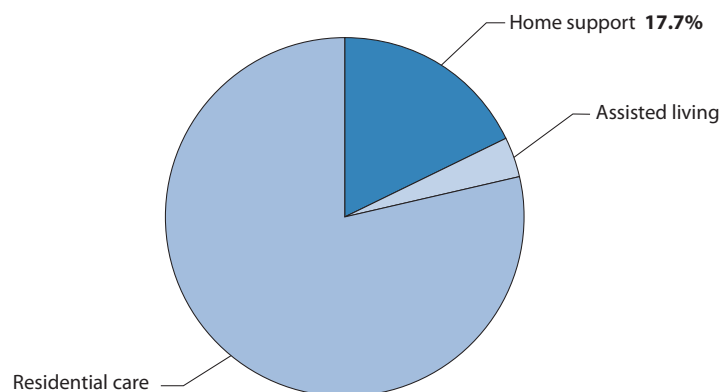
The challenges that we encountered in obtaining reliable or compatible data are discussed in “Collecting, Managing and Reporting Information” in the Home and Community Care section of this report.

The number of seniors who receive home support services and the hours of services they receive are examples of key program information that should be tracked at both the health authority and provincial levels and reported publicly in an annual report.

Funding Levels

The amount spent by the provincial government on subsidized home support services in 2008/09 represents 17.7 per cent of the overall budget for home and community care programs and services. The amount spent on subsidized home support in British Columbia has generally increased between 2002/03 and 2010/11. In 2009/10, the cost of providing home support services in British Columbia was approximately \$339 million. This is just under 15 per cent of the province’s overall funding for home and community care services for 2009/10.

Figure 3 — Allocation of Home and Community Care Budget, 2008/09



As discussed in the Home and Community Care section of this report, the Ministry of Health decides at the beginning of each fiscal year how much funding each health authority will receive. Individual health authorities then decide how to distribute those funds to meet their service delivery obligations, which, in addition to home and community care, include hospitals, mental health and public health services.

When we asked the health authorities how they decide how much money to set aside for home support services, they said they take a number of factors into account. They review what was spent during the previous year and then also consider:

- predicted population and health status changes
- program and service changes
- the government’s introduction of new policies
- the potential for increased costs of service delivery

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After examining all these factors, the health authorities decide on the final funding levels for home support services. The following table shows the funding each health authority devoted to home support services between 2002/03 and 2010/11.¹⁸⁵ It is not clear how the yearly fluctuations in funding are consistent with approaches health authorities told us they take when they decide how much money to set aside on an annual basis for home support services.

Table 11 – Funding for Long-Term Home Support Services by Health Authority 2002/03 to 2010/11

Health authority*	2002/03 (\$)	2003/04 (\$)	2004/05 (\$)	2005/06 (\$)	2006/07 (\$)	2007/08 (\$)	2008/09 (\$)	2009/10 (\$)	2010/11 (\$)
FHA	72,120,000	62,820,000	61,369,000	63,488,000	68,340,000	69,742,000	71,015,000	81,400,000	81,801,000
IHA	39,148,000	42,193,000	42,399,000	43,975,000	47,626,000	46,992,000	46,703,000	45,562,000	45,714,000
NHA	9,333,000	10,862,000	11,541,000	11,698,000	12,501,000	12,526,000	14,222,000	13,867,000	14,048,000
VCHA	71,538,000	64,731,000	62,514,000	78,821,000	80,808,000	77,978,000	82,872,000	87,073,000	88,045,000
VIHA	59,056,000	82,516,000	79,962,000	92,498,000	96,570,000	98,529,000	105,364,000	110,900,000	110,900,000
Provincial total	251,195,000	263,122,000	257,785,000	290,480,000	305,845,000	305,767,000	320,176,000	338,802,000	340,508,000

*Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

As the table above shows, both Fraser Health and Vancouver Coastal Health significantly reduced their funding for subsidized home support services in 2003/04, with another smaller reduction of funding in 2004/05. VIHA's subsidized home support services funding also declined in 2004/05. Since 2005, four of the health authorities have annually increased funding for home support services.¹⁸⁶ The exceptions to this trend were in 2007/08, when Vancouver Coastal Health home support funding declined, and in 2009/10 and 2010/11, when VIHA home support funding remained the same. Interior Health's home support services funding has declined each year from 2007/08 through 2009/10.

Apart from decreases in some health authorities during some fiscal years, the overall funding for home support has generally increased since 2005/06.

In a report released in October 2008, the Office of the Auditor General of British Columbia looked at whether the Ministry of Health Services was acting effectively as a steward by ensuring that the home and community care system has the capacity to meet the needs of British Columbia's residents, both now and in the future.¹⁸⁷ The Auditor General concluded that the ministry did not have a comprehensive planning framework for home and community care and recommended that it expand its planning and analytical tools in a number of key ways. Among other things, the Auditor General recommended that the ministry develop capacity indicators for all home and community care services, incorporate information on costs

¹⁸⁵ Note that the table shows funding for all long-term home support services, not just services for seniors.

¹⁸⁶ From 2002 to 2008, the cumulative effect of inflation was estimated at 11.8 per cent. In 2009, the rate of inflation was very low — only 0.1 per cent. So, while the total increase in funding from 2002 to 2009 was 43 per cent, after taking inflation into account, the actual increase was only 32 per cent.

¹⁸⁷ Office of the Auditor General of British Columbia, *Home and Community Care Services: Meeting Needs and Preparing for the Future*, October 2008.

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and population needs into program planning, and coordinate its research and evaluation cycle with the health authorities.¹⁸⁸ Given the demographics, we expected that the funding for home support services would at least remain constant. This is not the case. The yearly fluctuations in funding for home support services indicate that this is an area that would benefit from more attention and highlight the importance of implementing the auditor general's recommendations.

Enhanced transparency with respect to the funding of home support would help to identify significant fluctuations in funding and differences between planned and actual results. As recommended in the Home and Community Care section of this report, the ministry should report publicly on an annual basis the funding allocated for home and community care services, including home support, in each health authority and the planned and actual results of that funding.

Public Information

Seniors and others need clear, comprehensive and accessible information about the type of home support services that are available (or not available), including eligibility criteria, how to apply, costs, and who to call with questions or concerns. If seniors and their families do not have basic information about home support services, they will not be in a good position to advocate for themselves or their relatives, or to complain if services are not meeting standards.

When we began our investigation, we had concerns about the amount of information that was provided to the public about home support services. While the ministry itself still provides limited information about home support services, it now expects the health authorities to provide information about program access and intake and screening processes, as well as contact information for designated staff responsible for receiving complaints.

During the course of our investigation, we noted improvements in the information on home support that each health authority was making available on its website. Each health authority now provides online information about home support eligibility criteria, how to apply, relevant contact information and the cost of services.¹⁸⁹ We noted two examples of particularly useful information. One was the *VIHA Home and Community Care Client Handbook*, which is a clear and detailed source of information about home and community care programs, including home support.¹⁹⁰ This publication is available both in print and on VIHA's website. We also noted that Vancouver Coastal Health is the only health authority that provides printed information in multiple languages (Chinese, Farsi, French, German and Punjabi).

¹⁸⁸ Office of the Auditor General of British Columbia, *Home and Community Care Services: Meeting Needs and Preparing for the Future*, October 2008, 39-45. Further information about the Auditor General's report can be found under "Funding" in the Home and Community Care section of this report.

¹⁸⁹ The Interior Health Authority updated its Home and Community Care brochure in the fall of 2011 and reported that it is to be distributed to new clients at intake and to existing clients at the time of their next clinician visit.

¹⁹⁰ Vancouver Island Health Authority, *Home and Community Care Handbook for Clients*, February 2009 (revised February 2010) <http://www.viha.ca/NR/rdonlyres/AB8F383E-5C3A-461F-9E0E-D8D6457AE0E4/0/hcc_client_handbook.pdf>.

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Eligibility, Assessment and Access

All British Columbia residents, or persons acting on behalf of residents, can apply to receive subsidized home support services from their regional health authority. While being a senior is not a condition of eligibility for home support, seniors are the majority of home support clients, making up about 84 per cent of long-term home support clients between 2002/03 and 2007/08, the last year for which we have complete data .

When someone submits an application, a health professional, usually a case manager, visits the person at home to conduct an assessment.¹⁹¹ Family members may be present for the visit, if the person being assessed agrees. In order to be eligible for home support, applicants must have been assessed by the health authority as being in need of personal assistance and/or of respite for their caregivers, and must have agreed to pay the assessed client rate.¹⁹² They must also meet the citizenship and residency requirements described in the Home and Community Care section of this report.¹⁹³

"What my relatives need is someone to come and prepare meals, but this is not an option. They would stay in their home longer, but need more help than they are entitled to."

Source: Respondent, Ombudsperson's questionnaire.

The health professional will decide, based on his or her assessment of the person's health status, whether the applicant qualifies and is approved for home support services and how much home support will be provided. If the person is deemed eligible, the health professional will then use a formula that is set by provincial regulation to determine how much the person will pay. The formula is based on the person's after-tax income from the previous year. Those whose income is too high to qualify for subsidized services will have to pay the full rate in order to receive services.¹⁹⁴

While the provincial government's broad objective for home support is to have a program that assists "clients to live in their own homes as long as it is practical and in the best interests of the client and their family," the policies developed by the Ministry of Health are noticeably more restrictive.¹⁹⁵ According to the current *Home and Community Care Policy Manual*, health authorities must provide home and community care services "to supplement, rather than replace, the efforts of individuals and their caregivers to meet their health needs and make decisions about lifestyle and care."¹⁹⁶ This means that when conducting an assessment, health authority staff ask applicants about the types of support and assistance their family members can provide and take this into account when deciding on the number of home support hours

¹⁹¹ The Ministry of Health's *Home and Community Care Policy Manual* defines "health professional" as a registered nurse, registered psychiatric nurse, licensed practical nurse, occupational therapist, physiotherapist or social worker.

¹⁹² Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Home Health Services: Home Support Services, 4.B.1.

¹⁹³ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Eligibility, 2.B.

¹⁹⁴ Circumstances in which no client rate is charged, due to time-limited service rather than continuous home health service being received, are outlined in the Ministry of Health's *Home and Community Care Policy Manual*, April 2011, Client Rates, 7.B.2.

¹⁹⁵ Ministry of Health, *Home and Community Care Policy Manual*, April 2007, Community Support Services: Home Support, 5.A.1.

¹⁹⁶ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Overview: Home and Community Care Services, 1.A.

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each person will receive. However, the types of care that family members may be able to provide can change unexpectedly, regardless of their level of commitment and caring. Also, the help that families provide may, by necessity, be more sporadic than required to meet the seniors' care needs.

Once a health professional has decided that an applicant is eligible for home support services, he or she will develop a care plan that sets out the range of services the person will receive. The care plan should be developed in collaboration with the person, his or her caregiver(s) and other members of the person's health care team, as appropriate.¹⁹⁷

The ministry's *Home and Community Care Policy Manual* states that the home support services that health authorities provide to eligible clients should meet all of the following standards:

- allocation of home support services must be based on assessment of the client's health and functional status, the ability of the client and caregivers to manage care needs with available community supports, the client's established health care goals, and assessment of risk to staff
- priority must be given to clients who have been assessed as having the highest care needs or as living at the highest levels of risk
- services must be provided in a manner that reflects the requirement to balance care needs and safety issues within available resources — no client will be denied home support services solely on the basis of the cost of the service required by that client services will be available for a 24-hour period, on a short-term basis, where feasible and appropriate
- services may be authorized prior to assessment in urgent, exceptional situations, including outside of regular business hours¹⁹⁸

Care plans should provide details on the services a health authority has decided are necessary for each client. These may include safety maintenance, laundry, bathing, meal preparation, medication management or other home support services. Care plans should also indicate how much time a health authority has allotted for each service.

In addition to the ministry's policy, each health authority has developed guidelines for staff to use when deciding which home support services and how many service hours each client will receive. These guidelines all state that home support services are not intended to replace the support that others may be able to provide for clients and that all other options must be explored before making decisions about home support services.

The guidelines that Vancouver Coastal Health and Fraser Health provided us with were more comprehensive than those we received from VIHA, Interior Health or Northern Health and included standard time allotments for various activities.¹⁹⁹ We noted that Vancouver Coastal Health generally allowed more time for various tasks than Fraser Health. Some examples follow:

¹⁹⁷ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Assessment, 2.D.

¹⁹⁸ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Home Health Services: Home Support Services, 4.B.2.

¹⁹⁹ Since our review of the health authorities' guidelines, the Interior Health Authority told us that as of April 2011 it uses an adaptation of the Fraser Health Authority's guidelines to guide the time allotment for tasks.

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Meal Preparation

- Fraser Health allots no more than 10 minutes per meal, including cleanup
- Vancouver Coastal Health allots 30 minutes per meal

Assistance with Eating/Feeding

- Fraser Health allots 15 to 30 minutes per meal, noting that additional time may be required
- Vancouver Coastal Health allots 30 minutes per meal

Lifts/Transfers

- Fraser Health allots 5 to 10 minutes per mechanical lift, noting that additional time may be required
- Vancouver Coastal Health allots 5 to 20 minutes for a pivot transfer and 15 to 30 minutes for a lift transfer

Medication Management (requiring delegation of task)

- Fraser Health allots 5 to 10 minutes, noting that additional time may be required
- Vancouver Coastal Health allots 5 to 15 minutes

We realize that in addition to using these guidelines, health professionals rely on their clinical judgment to determine the home support tasks that need to be included in each person's care plan. However, it is difficult to understand why the amount of time that it is considered necessary to safely perform a home support task should vary by region. While there may be exceptions in which this variation is justified, overall these variations illustrate the need for provincial standards for home support services.

The Ombudsperson finds that

F30. The Ministry of Health has not ensured that time allotments for home support activities are adequate and consistent across the province.

The Ombudsperson recommends that

R35. The Ministry of Health work with the health authorities to develop a consistent province-wide process for determining adequate time allotments for home support activities.

Waiting for Service

When we asked each health authority how long it takes for seniors to begin receiving home support services after being assessed and approved for those services, we learned that this information is not consistently tracked across the province. However, based on the information we were able to obtain, we learned that in some communities, the home support system is flexible enough to provide same-day service for those with

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an urgent need, but in some cases, seniors wait up to three weeks after being assessed and approved to begin receiving services. The ministry has not set a time frame or target for the delivery of home support services after assessment.

The inconsistent tracking of waiting times makes it impossible to know if, and for how long, seniors are waiting for home support services. Seniors assessed as requiring home support services have been determined to be at risk and in need of some care; it is important that they and their families know how long they can expect to wait for the help that they need. Establishing a timeframe for waiting for service after assessment and measuring the health authorities' efforts to meet that timeframe would be an important step towards offering more consistent and transparent service.

The Ombudsperson finds that

F31. The Ministry of Health has not established a time frame within which seniors are to receive home support services following an assessment.

The Ombudsperson recommends that

R36. The Ministry of Health set a time frame within which eligible seniors are to receive subsidized home support services after assessment.

The Ombudsperson finds that

F32. The health authorities do not consistently track and report the time it takes for seniors to receive home support services after assessment.

The Ombudsperson recommends that

R37. The health authorities track the time it takes for seniors to receive home support services after assessment and report the average and maximum times that eligible seniors wait to receive subsidized home support services to the ministry quarterly.

R38. The Ministry of Health report annually to the public on the average and maximum times that eligible seniors wait to receive subsidized home support services after assessment.

Cost of Receiving Services

In 2009/10, approximately 71 per cent of subsidized home support clients in British Columbia received the subsidized home support services they were determined as being eligible to receive free of charge. Seniors are not required to pay for home support services if they receive any of the following:

- the Guaranteed Income Supplement, or the spouse's or survivor's allowance provided under the *Old Age Security Act*
- income assistance provided under the *Employment and Assistance Act*

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- disability assistance provided under the *Employment and Assistance for Persons with Disabilities Act*
- a war veteran's allowance provided under the *War Veterans Allowance Act*

Among the 29 per cent of home support clients who paid toward subsidized home support services in 2009/10, 3 per cent paid up to \$10 per day, 6 per cent paid between \$10 and \$20 per day and 20 per cent paid more than \$20 per day.²⁰⁰ Seniors and other home support clients who are assessed as not eligible for a subsidy must pay the full cost of services, which is typically \$30 to \$40 per hour, using their own funds.

The formula that determines how much seniors who are eligible for a subsidy will be charged is set by the *Continuing Care Fees Regulation*. The formula uses income information from the preceding tax year and includes spousal income, if applicable. For example, the rates that became effective January 1, 2010, were based on seniors' income information for 2008.²⁰¹ The health authorities calculate seniors' fees each year, and are supposed to inform them of any changes by letter before the changes take effect.

It typically costs the health authorities \$30 to \$40 for each hour of subsidized home support services they provide, whether those services are delivered directly by health authority staff or by a contracted agency. Wages and benefits for home support workers make up much of this cost. Employee travel time and transportation are also factors.

Hardship Waivers

According to the Ministry of Health, the formula for calculating the home support rates charged to seniors is designed to ensure that they and their spouses retain enough money to pay for expenses other than home support.²⁰² If paying the rate produced by the provincial formula would cause financial hardship, seniors can apply to their regional health authority for a hardship waiver. This option is available to seniors whether

²⁰⁰ Ministry of Health, letter to the Office of the Ombudsperson, 16 June 2011 with undated "Home Support" fact sheet.

²⁰¹ The daily charge for home support services is arrived at by assessing the annual income of the client and his or her spouse, where applicable, deducting certain specified amounts and then multiplying the "remaining annual income" by 0.00138889. The "remaining annual income" is established by a formula that considers various amounts from the client and spouse's income tax returns from the preceding tax year. Various allowable amounts set out in regulation, along with an income deduction based on family size, are deducted from the client and spouse's net income (line 236 of the tax return). Ministry of Health staff explained that multiplying by 0.00138889 provides the same total as dividing 1 by 720 (720 is equal to 12 months × 30 days × 2). Annual income is divided by 12 months to obtain the monthly "available" income (after taxes and other basic living expenses are deducted). This monthly available income is divided by 2 to obtain a monthly amount, which is divided by 30 days to obtain a daily rate. Clients are charged for days on which they receive service and pay the same amount each day, regardless of how much service they receive. Earned income is defined in the *Continuing Care Fees Regulation* as "the sum of the following amounts as reported on lines 101, 104, 135, 137, 139, 141 and 143 of the client's or his or her spouse's income tax return for the immediately preceding taxation year: (a) employment income; (b) other employment income; (c) net business income; (d) net professional income; (e) net commission income; (f) net farming income; (g) net fishing income." *Continuing Care Fees Regulation*, B.C. Reg. 330/97, s. 1.

²⁰² The ministry defines this value as half of the combined "remaining annual income."

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they live in their own home or a facility. Section 6 of the *Continuing Care Fees Regulation* states that daily home support charges for a person who lives in a facility or family care home can be waived for up to a year because of financial hardship.

When health authorities notify seniors in writing that their rate will be changing, they inform them that they can contact their case manager if they have any questions or concerns. However, these letters do not make it clear that seniors can ask for a hardship waiver. This issue is discussed in more detail in “Fees and Fee Waivers” in the Home and Community Care section of this report.

Costs for Seniors with Earned Income

While many seniors have income only from private or public pensions or government programs, some also earn income from employment or running a business. In November 2007, the provincial government placed a cap on the amount that seniors who have what is referred to as “earned income” can be charged for home support.²⁰³ Earned income is defined in the *Continuing Care Fees Regulation* as the sum of employment income, net business income, net professional income, net commission income, net farming income and net fishing income.

Under section 3(1.1) of the *Continuing Care Fees Regulation*, home support fees for seniors (or their spouses) who earn even a small amount are capped at \$300 per month, while no cap applies to the fees charged to seniors who have the same overall income but no earned income. The Regulation does not prescribe a minimum amount that seniors must earn in order for the cap to apply.

Also, the Regulation sets out that home support clients and their spouses may deduct earned income from the amount of income that is used to calculate their rates, up to a maximum of \$25,000 per person and \$50,000 per couple.

The stated intention of these provisions of the Regulation is to encourage people with disabilities, including seniors, to earn income. However, the result is that seniors who have a relatively large income that includes some earned income may pay lower home support fees than seniors with less overall income but no earned income. There appears to be no clear rationale for this.

Did You Know?

Seniors who report any “earned income” on their yearly tax returns — there is no minimum amount — will have their home support fees capped at \$300 per month when the health authority assesses the applicable home support rate.

Source: *Continuing Care Fees Regulation*, B.C. Reg 330/97.

²⁰³ In November 2007, (Order in Council No. 799) the government amended the definition of “qualified client” in the *Continuing Care Fees Regulation* by removing the “aged 19 to 64” criterion, making seniors eligible for this cap. In January 2010, this Regulation was amended to replace “qualified client” with “client”, defined as a person who is receiving continuing care.

Home Support

The Ombudsperson finds that

- F33. It is unfair for the Ministry of Health to treat seniors without earned income differently than seniors with earned income for the purposes of capping monthly fees for home support services at \$300 per month.

The Ombudsperson recommends that

- R39. The Ministry of Health take the steps necessary to extend the \$300 monthly cap to seniors who do not have earned income so that they are treated the same way as those seniors who do have earned income.

Continuity of Care

Seniors and their families told us it was not uncommon for them to have many different and unfamiliar workers coming to their homes to provide home support services. This lack of continuity is one of the concerns that we heard most frequently from seniors who receive home support services.

One of the problems with a high rate of turnover in home support workers is that it takes time to familiarize a new worker with a particular senior's home, medical condition and care needs. This leaves less time available for the worker to provide the actual service.

In addition, home support is often provided with the goal of preventing a senior from becoming sicker or frailer, or from having to be institutionalized. In order to realize this goal, the workers who provide home support services must be familiar enough with a senior's condition to notice when that condition is changing and respond appropriately. As well, like anyone else, seniors may be more comfortable talking about illnesses or health problems to those who are familiar to them. Home support workers often provide very personal services, such as bathing, dressing or helping clients to use the toilet. Most people would feel more comfortable receiving these types of services from people who are familiar to them. High turnover among home support workers means this degree of familiarity and trust is less likely to be achieved.

Seniors may also have security concerns. Most people are reluctant to allow people they don't know to enter their homes. In the case of seniors, this may be especially so, given their greater physical vulnerabilities.

"It is extremely difficult to get anyone on a regular basis. ... This means that, effectively, I have to teach each new person my mother's special needs and what should be done by demonstrating the task. How useful is that? It is also frustrating, I expect, for the workers not to know how to handle each new client, someone they may never see again. ... A person suffering from Alzheimer's needs stability, not a steady stream of strangers who only add to the confusion."

Source: Respondent, Ombudsperson's questionnaire.

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The standards that apply to home support and other continuing care programs today were developed in 1999 by the Ministry of Health and the Ministry Responsible for Seniors. These standards include an “expectation” that consistent staff assignments will be maintained when possible, in order to support clients to remain at home and to achieve an optimal level of health and well-being.²⁰⁴

All of the health authorities told us that they strive to provide continuity in home support staffing. They find that achieving this is often difficult, however, because of service changes on short notice, the uncertain availability of workers, collective agreement requirements, budget restrictions and unique client needs.

Only two of the health authorities, Fraser Health and Vancouver Coastal Health, have specific policies on home support worker continuity. Both use a performance-based funding model. These health authorities and VIHA use a cluster care model. VIHA uses this model in the higher-density areas of Victoria, Salt Spring Island and the Saanich Peninsula. In this model, a team of workers delivers services to a group of clients who live close together. Vancouver Coastal Health has used this model for some time for the services it provides through contracted service providers in Vancouver, and more recently implemented it in Richmond and the North Shore for services it provides directly.

An evaluation of Richmond’s cluster care model in March 2010 showed a 58 per cent reduction in the number of different home support workers per month who visited 18 clients who receive frequent service. In one cluster on the North Shore, it was reported that clients had the same worker each day, except for occasional sick leave replacements.

Since April 1, 2010, Fraser Health has been working with its main service providers to put clusters together in its higher-density areas. Staff told us that Fraser Health should be able to provide statistical information about the continuity of home support workers for clients within these clusters late in 2011.

Both Fraser Health and Vancouver Coastal Health have been trying another approach to providing home support that is designed to improve the quality of service. Accountability, Responsiveness and Quality for Clients (ARQ) has been used by Vancouver Coastal Health and its service providers for the higher-density areas in Vancouver since 2006. Key elements of the ARQ model are the use of performance indicators and performance-based funding incentives. Under this model, service providers must meet the targets outlined in service agreements and may receive extra funding when they exceed certain performance targets. One of the performance indicators is the number of clients who receive services from the same home support workers on a “consistent” basis.

Best Practice: Vancouver Coastal Health Authority Cluster Care Model

Cluster care is a way of providing care to a number of clients who live in the same building or in close geographic proximity to one another.

Vancouver Coastal Health has been using this model in its high-density areas in Vancouver, Richmond and the North Shore to help reduce the number of complaints it receives from home support clients about lack of continuity in the staff who provide home support services.

The Fraser Health Authority has also been working with its service providers since April 2010 to begin providing cluster care in its higher-density areas.

²⁰⁴ Ministry of Health and Ministry Responsible for Seniors, *Model Standards for Continuing Care and Extended Care Services*, April 1999, Home Support Services: Care and Services, Standard 3, Criteria 3.10.

Home Support

Vancouver Coastal Health measures consistency of service for a given client over a three-month period, with the targets varying depending on the frequency of visits. For example, if a client receives two to three visits per week, services should be provided by three or fewer workers over the three-month period (barring sick leave, vacation or other extenuating circumstances), and clients who receive two visits per day should receive services from six or fewer workers over the same period. Vancouver Coastal Health's expectation is that at least 80 per cent of clients will receive services from the same group of workers consistently. Service providers who surpass this target may get funding bonuses.

Fraser Health directed all but one of its home support service providers to adopt the ARQ model by April 1, 2010.²⁰⁵ In December 2010, Fraser Health reported that for the first quarter, two of its three Vancouver agencies had consistency rates of 72 per cent and 77 per cent in the number of home support clients who received services from the same home support workers on a consistent basis. The third agency achieved a 41 per cent consistency rate. (Results are available only for the first quarter, since the model is still in its trial phase.) In January 2011, Fraser Health began using the ARQ model for home support services that it provides directly. It has indicated that evaluation reports are not yet available.

As mentioned previously, Fraser Health has been working with its service providers to implement the cluster care model in its higher-density areas. Where distances or the number of service hours make the cluster care model unsuitable, Fraser Health hopes that 85 per cent of non-cluster care clients will still receive a high degree of continuity of care under the ARQ model.

Analysis

While there are ongoing challenges involved in providing continuity of care for home support clients, if home support is to play the prevention role for which it is intended, it is critical that seniors be able to establish reliable, ongoing relationships with home support workers. Taking further steps to prioritize continuity of care in home support would promote the health, well-being, independence and dignity of seniors.

The Ombudsperson finds that

F34. While continuity in staffing is recognized as important in home support services, the Interior Health Authority, Northern Health Authority and Vancouver Island Health Authority do not incorporate this principle in their policies, service agreements and performance measures on a regular and consistent basis.

The Ombudsperson recommends that

R40. The Interior Health Authority, Northern Health Authority and Vancouver Island Health Authority include the principle of continuity in home support in their policies, service agreements and performance measures.

²⁰⁵ The Fraser Health Authority does not use this model for its "surge capacity" service provider. Surge hours are home support service hours provided to clients in circumstances where the existing Fraser Health teams do not provide the service. Surge hours are usually required for a short period and fluctuate each month. Due to the nature of surge hours, the ARQ model is not applicable.

Home Support

The Choice in Supports for Independent Living Program

The Choice in Supports for Independent Living (CSIL) program was introduced in 1994 to provide an option for people requiring care who wish to manage their own home support services. While health authorities manage the delivery of home support services to most seniors, those who want more direct control and choice over their care, and can show that they are able to do so, may prefer to use the CSIL program. To qualify for the CSIL program, seniors must be able to direct all aspects of their care, or have a designated representative through a valid representation agreement, or a client support group, that can do so for them.²⁰⁶ If approved for CSIL funding, the senior, representative or support group is responsible for hiring, scheduling and supervising the home support workers, as well as overseeing the care provided. An immediate family member (defined as parent, child or spouse) cannot be hired to provide care unless the senior, representative or support group has applied for an exception and the health authority has approved this exception.

The CSIL program underwent a provincial review in 2007. The review showed that participation in the program had grown every year since 2000. While there was a 30 per cent increase in clients and nearly a 50 per cent increase in the hours of service provided over the five-year period ending in 2006/07, currently about 3 per cent of home support clients use the CSIL program.

During our investigation, our office received complaints from seniors in different health authorities who were frustrated with the CSIL application process and were having problems accessing the program. Some seniors told us that their case manager did not make them aware of the CSIL option. Others found the application requirements and process confusing.

Although CSIL is a provincial program, the individual health authorities determine eligibility for the program and the application process varies from one region to another. One thing that does seem consistent is that gaining access to the program requires significant planning and organization on the part of applicants. The complaint that Jennifer brought to us is an example of the type of concerns we heard about the CSIL program. (The name below has been changed to protect confidentiality.)

Jennifer's Story

Jennifer contacted us about her application to VIHA's CSIL program. She had applied to manage her father's home support services because she was concerned about the quality of care he was receiving and the number of different home support workers he'd had. Unfortunately, the application process took almost six months, and her father passed away before the application was approved.

Jennifer had discussed the CSIL option with her father's case manager, who helped her to complete several parts of the application. The case manager had taken part of the application and instructed Jennifer to complete the rest on her own and submit it to the home and community care office. Jennifer did this within three days. Three weeks later, the case manager assured her that all the paperwork necessary for the application was complete and had been submitted. Since her father had immediate care needs and she expected the application to be approved without delay, Jennifer went ahead and hired a home support worker.

²⁰⁶ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Home Health Services: Choice in Supports for Independent Living (CSIL), 4.C.1. A client support group is a group of five or more people who have registered as a non-profit society for the purpose of managing home support services on behalf of a CSIL client.

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Jennifer's application had to be passed on from VIHA's home and community care office to the CSIL program office for approval. During our investigation, we learned that miscommunication and other errors made by the health authority delayed this transfer of documents. Health authority staff lost some parts of the application Jennifer had submitted and asked her to submit them again. The home and community care office faxed some documents to the CSIL office, even though the CSIL office required originals. Some of the information Jennifer submitted was considered inadequate, even though she had followed the instructions on the application and the case manager's guidance. At one point, Jennifer's application was mistakenly put on hold, pending receipt of a document she had not yet been asked to provide. This caused further delays.

We consulted VIHA about the way it processed CSIL applications and suggested that it pay Jennifer the money she would have received from the CSIL program if not for the unreasonable delay. As a result of our consultation, VIHA sent Jennifer a written apology. Although her father had already died, VIHA also paid her \$3,000 in recognition of the caregiving costs she had incurred while he was alive, and which would have been covered by the program if her application had been processed in a timely manner. VIHA also initiated a review of its CSIL program policy.

One thing that could help people who are in situations like Jennifer's is having more and clearer information about the CSIL program and application process available on health authority websites. The CSIL application process is understandably complex, as the CSIL program involves providing individuals and members of the public with funds to purchase and manage their own services. The small number of home support clients who make use of the CSIL program, may well reflect the lack of public information about the program and its application process. Deficiencies in the information provided about CSIL limit the probability of seniors and their caregivers considering CSIL as an option.

In our review, we found that none of the health authorities has a complete description of the CSIL program's application process on its website.²⁰⁷ VIHA's website now provides the most information, including a description of the program and its eligibility criteria, as well as information on funding and client responsibilities. Fraser Health, Interior Health, Northern Health and Vancouver Coastal Health each provide a brief explanation of the CSIL program, and Fraser Health also lists the program's eligibility criteria.

The Ombudsperson finds that

F35. The Ministry of Health has not ensured that the Choice in Supports for Independent Living (CSIL) application process is standard across the province and that clear information about the CSIL program is provided to seniors and their families.

The Ombudsperson recommends that

R41. The Ministry of Health establish a standard Choice in Supports for Independent Living application process and ensure that clear and accessible information about that application process is made available by the health authorities.

²⁰⁷ Information about the CSIL program can be found in the following report: Ministry of Health, *Choice in Supports for Independent Living (CSIL) Program Review*, November 2008 <http://www.health.gov.bc.ca/library/publications/year/2008/CSIL_Review_2008.pdf>.

Home Support

Quality of Care

The Absence of Provincial Standards

Home support services are administered under the *Continuing Care Act*.²⁰⁸ While the Act covers a broad range of care programs, it does not include specific legislative or regulatory requirements for home support. Instead, the Act authorizes the Minister of Health to issue “standards, guidelines or directives” that are binding on home support service providers.²⁰⁹

Ministry of Health staff confirmed that there have been no provincial standards, guidelines or directives created for home support under the *Continuing Care Act* since it came into force in 1990. This absence of specific and binding standards for home support is one of the issues we investigated. Standards are an important way to establish a legally binding minimum baseline for service delivery in order to protect vulnerable seniors.

Ministry staff said health authorities are expected to ensure that publicly funded home support services comply with the policies in the ministry’s *Home and Community Care Policy Manual* and, where applicable, its *Model Standards for Continuing Care and Extended Care Services*, its *Personal Assistance Guidelines* and the accreditation standards set by Accreditation Canada.²¹⁰ However, ministry staff confirmed that these documents are not considered standards, guidelines or directives pursuant to section 4 of the *Continuing Care Act*, meaning that they are not binding and do not have the force of law.

²⁰⁸ *Continuing Care Act*, R.S.B.C. 1996, c. 70.

²⁰⁹ *Continuing Care Act*, R.S.B.C. 1996, c. 70, s. 4(4).

²¹⁰ Ministry of Health and Ministry Responsible for Seniors, *Model Standards for Continuing Care and Extended Care Services*, April 1999; Ministry of Health, *Personal Assistance Guidelines*, November 2008. The *Personal Assistance Guidelines* clarify the boundaries of practice, and the roles and responsibilities of unregulated care providers.

Personal Assistance Guidelines

The Ministry of Health developed the Personal Assistance Guidelines in 1997 and revised them in 2008. The guidelines outline the roles and responsibilities related to personal assistance tasks, and the procedures through which these tasks may be delegated to and performed by home support workers, who are unregulated care providers.

In some instances, a health care professional, such as a registered nurse, occupational therapist or physiotherapist, may choose to delegate a task that he or she is authorized to perform to a home support worker.

Situations where delegation from a health professional to a home support worker might occur include medication administration, prosthetics care, catheter care, administration of eye drops, assistance with ventilator equipment, and assistance with range of motion exercises.

Under the Personal Assistance Guidelines, a delegated task must be client-specific. It is up to the organization that is providing home support to decide whether to accept the delegation.

If delegation is accepted, the home support worker must be provided with the training necessary to carry out the delegated task and must also be subject to ongoing assessment of his or her ability to perform it.

The health care professional retains responsibility for the client’s care planning and evaluation.

The guidelines do not define or limit the tasks that may be delegated.

Home Support

Although they are not binding, the ministry's *Model Standards for Continuing Care and Extended Care* do contain some policies for home support. However, they were developed in 1999, well before the current provincial model for home and community care programs came into effect. The complete list of policies for home support is as follows:

- inform clients of services they will receive
- identify and address client care and service requirements in a current, individualized written service plan
- support clients to remain in their homes and achieve an optimal level of health and well-being
- document care and services provided to the client
- ensure active client and family involvement in evaluating care and services²¹¹

While these policies are laudable, some are too general to be used as objective performance measures. For example, there is no detail on how the health authorities could measure whether the support provided to clients has allowed them to remain at home and achieve “an optimal level of health and well-being.” In order to be effective, standards need to be specific and measurable, and they must be monitored to ensure that they are applied.

Provincial standards that define the type and level of care to be provided, minimum qualifications and training for staff, and procedures for reportable incidents would assist in ensuring that the delivery of home support services can be consistently and effectively monitored. This in turn would allow the health authorities and the ministry to appropriately carry out their oversight roles.

Development of provincial standards and guidelines for the home support program would help ensure that all seniors in British Columbia are supported through similar service delivery.

Accreditation

Health authorities rely to varying degrees on the accreditation of home support service providers as a means to ensure quality of care in this area. Each of the regional health authorities are accredited through Accreditation Canada, which means that the home support services they provide directly are also accredited.²¹²

However, not all health authorities require their contracted home support providers to be accredited. Fraser Health and VIHA do require accreditation, but until recently Vancouver Coastal Health did not and Interior Health still does not. Northern Health does not use contracted service providers to provide publicly subsidized home support services.

The accreditation process occurs in a three-year cycle, with on-site reviews generally conducted once during that period. Accreditation requires organizations to conduct self-assessments, gather data and conduct on-site surveys. In order to achieve and maintain accreditation, organizations must have a policy on how they will report and follow up on events that result in a client's death or major loss of function, and on other adverse

²¹¹ Ministry of Health and Ministry Responsible for Seniors, *Model Standards for Continuing Care and Extended Care Services*, April 1999, Home Support Services, Standards 1-5.

²¹² All of the health authorities in British Columbia were accredited as of December 31, 2009.

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events and near misses.²¹³ Who the event must be reported to is not specifically defined; however, the organization must comply with any applicable legislation and act within any protection afforded by legislation.²¹⁴

Accreditation Canada has eight required organizational practices related specifically to home care:

- ongoing effective training for staff and service providers on infusion pumps
- safety risk assessments conducted for clients receiving services in the home
- the use of at least two client identifiers before providing any services or procedures, to avoid errors due to client misidentification
- a formal process to reconcile client medications at the time of referral and transfer and for communication about medications to the next provider
- mechanisms for effective and timely information transfer among service providers at transition points
- implementation and evaluation of a falls prevention strategy to minimize the impact of client falls
- information and education of clients and families about their roles in promoting safety
- implementation of verification processes and other checking systems for high-risk activities²¹⁵

While accreditation is useful it can only supplement not replace government regulation, monitoring and enforcement.

Accreditation Canada

Accreditation Canada is an independent non-profit organization that accredits national and international clients.

Participating organizations undergo an assessment against a set of national standards developed by Accreditation Canada. The assessment results in an action plan for improving service delivery.

The home support standards that Accreditation Canada has developed include:

- *investing in home care services*
- *engaging prepared and proactive staff*
- *providing safe and appropriate services*
- *maintaining accessible and efficient clinical information systems*
- *monitoring quality and achieving positive outcomes*

²¹³ Accreditation Canada defines a “near miss” as an event or situation that could have resulted in an accident, injury or illness to a client but did not, either by chance or through timely intervention.

²¹⁴ Accreditation Canada, Qmentum Program, *Required Organizational Practices*, February 2011, “Adverse Events Reporting,” 5.

²¹⁵ Accreditation Canada, Qmentum Program, *Required Organizational Practices*, February 2011. Examples provided by Accreditation Canada include checking systems for water temperature for client bathing and standardized tracking sheets for clients with complex medication management needs.

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Progress

The ministry's revised *Home and Community Care Policy Manual*, which became effective on April 1, 2011, includes a new chapter on performance management outlining the need for an approach to home and community care services that includes the following four components: performance standards, performance measures, reporting of progress and quality improvement.

The policy also states that "provincial performance standards and measures will be developed collaboratively with health authorities."²¹⁶ While this is a step in the right direction, the ministry and health authorities have yet to set the standards called for and the policy is not binding.

Analysis

There is a need for specific, consistent and legally binding provincial standards for quality of care in home support services. The creation of home support standards under section 4 of the *Continuing Care Act* would provide a useful administrative framework for health authorities and would support consistency in the level and quality of home support provided throughout the province.

The Ombudsperson finds that

- F36. The Ministry of Health has not exercised its power under section 4(4) of the *Continuing Care Act* to establish specific quality of care standards for home support services.

The Ombudsperson recommends that

- R42. The Ministry of Health exercise its power under section 4(4) of the *Continuing Care Act* to establish clear, specific and enforceable quality of care standards for home support services, including the type and level of care to be provided, minimum qualifications and training for staff, complaints processes and procedures for reportable incidents.
- R43. The Ministry of Health require health authorities to provide information about these standards to home support clients.

Complaints

"Clients who express concerns to their workers often are reluctant to contact the agency directly, fearing that they will be branded as complainers."

Source: Home support worker.

Home support services are usually provided for seniors by home support workers in private homes. Many of the services provided, such as assistance with eating, dressing, bathing or using the toilet, are very personal or intimate. Given the nature of home support services, the environment in which they are typically delivered and the vulnerability of the clients served, it is particularly important that seniors and other home support clients

²¹⁶ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Performance Management: General Description, 3.A.

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have access to a clear, transparent and timely complaints process when they are dissatisfied with or have concerns about those services. For a complaints process to be effective, it is also critical that seniors are confident that making a complaint will not have adverse consequences.

The Ministry of Health's revised *Home and Community Care Policy Manual* states that health authorities are required to have a clearly defined appeal process for client disputes about health service decisions related to home and community care services, including home support.²¹⁷ The provincial standards for continuing care programs (including home support), which were set out by the former Ministry of Health and Ministry Responsible for Seniors in April 1999, state that those providing continuing care services should have a formal complaints process in place; however, these standards are not legally binding.²¹⁸ Apart from these general policies for all home and community care programs, and unlike residential care and assisted living programs, the home support program does not have specific policies regarding complaints.

Agencies Responsible

Seniors and their families are encouraged to raise any concerns about home support services with the person providing care as a first step. We heard from some seniors and family members who were uncomfortable bringing complaints directly to their care providers' attention. As with other home and community care programs, seniors and their families may be reluctant to complain about home support services because of their reliance on these services, or because they feel vulnerable. Seniors may be unsure about whom to raise their concerns with because they typically receive home support from many different workers. Seniors and their families can also be reluctant to bring complaints to the attention of a care provider's employer because they rely on a particular worker. These situations can be particularly sensitive when a service provider is the only source of subsidized home support in a community.

If a problem can't be resolved through discussion with the care provider, a senior receiving subsidized home support services currently has a number of options for complaining. These include taking the problem to:

- the contracted agency that employs the person who provided the service (if applicable)
- the health authority case manager
- the regional patient care quality office

Contracted Service Providers

Both the health authorities and contracted service providers told us that they expect seniors to first try to resolve any concerns they have with their service provider. Consequently, it is important that contracted service providers have their own complaints process and that they make clients aware of them. It is also important for contracted service providers to tell people who are not satisfied with the outcome of a complaint how to contact the health authority with their concerns.

When delivering services through a contracted agency, it is up to the health authorities to ensure that the service provider has an appropriate complaints process. However, health authorities' practices in this area are inconsistent, and not all service agreements explicitly require service providers to have a complaints

²¹⁷ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Appeal Process, 2.E.

²¹⁸ Ministry of Health and Ministry Responsible for Seniors, *Model Standards for Continuing Care and Extended Care Services*, April 1999, Organizational Functions: Risk Management, Standard 3, Criteria 3.1.

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process.²¹⁹ Fraser Health, Vancouver Coastal Health and VIHA require their contracted home support agencies to have complaints processes. This requirement is included in service agreements for these three health authorities. In addition, contractors with Fraser Health are required to inform it of any significant complaints they receive. We did not find similar requirements in the Interior Health service agreement. Northern Health does not use contracted service providers for home support.

Some Canadian provinces have more specific expectations for home support complaints processes. For example, New Brunswick's Department of Social Development has the following standards for processing complaints about home support service providers:

- respond within 48 hours
- make at least one contact with a complainant by telephone
- attempt to resolve the complaint
- notify the case manager if a complaint is unresolved and notify the case manager with details of the resolution of a complaint²²⁰

This specificity provides a framework for consistent complaints processes among service providers and consistent complaints processes for all home support clients.

In addition to having a complaints process, it is important for contracted services providers to inform people about the process. In May 2011, we conducted a review of the information available on the websites of several contracted home support providers. We reviewed the websites of five organizations that provide services for both Fraser Health and Vancouver Coastal Health, four Interior Health service providers and three VIHA service providers.²²¹ We were looking for information about a complaints process, including what the process was, who to contact to raise a concern, and who to contact if dissatisfied with the results of the service provider's complaints process. In our review of 12 websites, we found a total of four home support providers' websites that mentioned who to contact about complaints. A VIHA service provider provided the most information about its complaints process, including information about who to contact to discuss the matter and two further contacts within the organization to speak to if the concern remained unresolved. One Interior Health service provider and two that provide services for both Fraser Health and Vancouver Coastal Health identified the contact for complaints, but did not explain the process that would be used to consider the matter or what a person might do if still dissatisfied.

²¹⁹ All health authority service agreements require service providers to comply with the *Model Standards for Continuing Care and Extended Care Services* established by the former Ministry of Health and Ministry Responsible for Seniors in April 1999, which in turn require service providers to have formal complaints processes. However, this requirement on its own is unlikely to ensure that service providers develop and maintain clearly defined complaints processes.

²²⁰ New Brunswick Department of Social Development, *Home Support Services Standards*, August 2005, Section 5 (Service Management Responsibilities), 3.

²²¹ VIHA has one service provider for the south island area. VIHA staff deliver most services in the central and north island areas, with contracted agencies providing augmented home support services as required.

Home Support

The Ombudsperson finds that

- F37. The Interior Health Authority does not include a requirement in its contracts for home support providers to have clearly defined complaints processes.

The Ombudsperson recommends that

- R44. The Interior Health Authority require all of its contracted service providers to have a clearly defined complaints process.

The Ombudsperson finds that

- F38. The health authorities do not have a requirement in their contracts for home support providers to inform residents and families about how to complain about home support services and to report to the health authorities about the number, type and outcomes of complaints received.

The Ombudsperson recommends that

- R45. The health authorities require their contracted home support providers to inform residents and families about how to complain about home support services and report to the health authorities on the number, type and outcomes of complaints received once per quarter.

Health Authority Case Managers and Patient Care Quality Offices

In addition to complaining to their service providers, seniors who are not satisfied with the subsidized home support services they receive can complain to either their case managers or the regional patient care quality office.

Health authority case managers act as coordinators to help seniors obtain home and community care services, but are an option only for subsidized seniors who have complaints.²²² Case managers determine seniors' eligibility for services, and assess their health care needs, as well as the nature, intensity, duration and cost of the services required. If seniors or their families have concerns about subsidized services that they are not able to resolve with their caregivers, they can contact their case manager, who may help to resolve the concern. Complaints made to case managers are informal. There is no consistent process for receiving or responding to complaints at this level, nor do staff in each health authority consistently track these types of complaints. Tracking complaints made informally to case managers would help the health authorities to know not only the type and quantity of complaints made, but also whether those complaints were resolved, and if there are any systemic or recurring problems with service delivery that are responsible for multiple complaints.

²²² Note that the term "case manager" is no longer used in the ministry's revised *Home and Community Care Policy Manual*. According to the manual, assessments are to be done by a "health professional". Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Assessment, 2.D.

Home Support

Complaints to case managers and the patient care quality office are not available to seniors who receive home support services that are paid for privately. This inconsistency is concerning because all home support recipients should be able to access the same complaints processes regardless of how they pay for their services. As well, complaints from seniors receiving non-subsidized home support services, often from the same service provider as seniors receiving subsidized home support services, provide useful information to health authorities about problems with service delivery.

The Ombudsperson finds that

- F39. The health authorities do not keep track of complaints about home support that are made to case managers.

The Ombudsperson recommends that

- R46. The health authorities develop and implement methods for tracking complaints made to case managers about home support.

The Ombudsperson finds that

- F40. The Ministry of Health has not ensured that all seniors who receive home support services have access to the same processes for complaints.

The Ombudsperson recommends that

- R47. The Ministry of Health ensure that all seniors who receive home support services have access to the same complaints processes.

Public Information

Because home support services are provided in a client's home rather than in a facility, seniors may not always be able to promptly speak to staff or a manager to seek information on how to complain. This means that clear written information is important to guide them in this process. While some seniors can access information through the Internet, many do not. Up-to-date written material about complaints processes needs to be available to all home support clients in their homes.

In February 2009, the Minister of Health Services issued a directive requiring the health authorities to make information on how to complain about home and community care services available to the public. This information was to include details about review processes and direct contact information for the designated staff members responsible for receiving complaints in each area.

Each health authority's home and community care website contains a link to the website of its patient care quality office. Interior Health, Northern Health and VIHA also provide brief information on their websites about how to complain to their home and community care offices. The written information the health authorities provide for home support clients about complaints processes varies among health authorities.

Home Support

Fraser Health, Interior Health, Vancouver Coastal Health and VIHA refer people first to their service provider then to the patient care quality office. As of September 2011, Interior Health revised its *Home and Community Care Guide* to include how to report concerns. Before September 2011, the information provided by Interior Health referred people to an appeal process that was no longer available. Northern Health refers people to their case manager or the home support provider and does not mention the patient care quality office.

In addition to referring seniors to their home support providers and to the patient care quality offices, Fraser Health offers home support clients the right to ask for an appeal through the care provider or program manager. The process involves a review conducted by Fraser Health staff who have not been involved with the complainant's care. The review can take up to 30 days. If the complainant wishes, he or she can then request a review by an Appeal Committee, which is made up of Fraser Health staff and members of the public. The committee will meet with the complainant to hear an explanation of his or her concerns and then make a decision on the appeal. Fraser Health tracks these appeals through its executive director's office. Health authority staff told us that since October 2009, five clients have used the appeal process, one of whom also complained to the patient care quality office.

In order for a complaints process to be effective, written information about the process must be readily available to seniors who receive the service and their families. Written materials should inform clients about how to make a complaint, how the complaints process works, and what kind of response they can expect, from whom and in what time frame. Contact information for those responsible for handling complaints should be provided. The materials should also tell seniors what they can do if they are not satisfied with the steps taken in response to their concerns. Because of the nature of the services provided, it is also important that seniors be reassured that their care will not be affected if they submit a complaint.

Currently, the information provided to seniors and their families varies among health authorities and does not consistently include clear and detailed information about available complaints processes.

Best Practice: The Fraser Health Authority's "Giving Feedback" Fact Sheet

Fraser Health provides home support clients with a fact sheet that provides information about whom to complain or offer feedback to, who can make a complaint, what will be done in response to a complaint, how long it will take to receive a response, and what to do if they are unhappy with the outcome of a complaint, including how to request an appeal. The fact sheet also reassures seniors that their care will not be affected if they submit a complaint.

Home Support

The Ombudsperson finds that

- F41. The health authorities do not provide clear and consistent information for seniors and their families about how they can complain about home support services and how the health authorities will handle complaints.

The Ombudsperson recommends that

- R48. The Ministry of Health and the health authorities work together to develop and provide clear and consistent information for seniors and their families on how they can complain about home support services and how the health authorities will handle those complaints.

Monitoring and Enforcement

Monitoring involves checking and keeping track of whether, and to what degree, service providers are meeting applicable standards and requirements. Enforcement involves responding to instances of non-compliance through a continuum of measures ranging from education to increasingly serious consequences. Enforcement is often more effective when increasingly serious consequences, ranging from warnings to contract suspension or cancellation, are applied in response to repeated instances of non-compliance.

As there are no binding provincial standards for home support, it is difficult for the Ministry of Health and the health authorities to monitor the quality of home support services. It also limits the consistent evaluation of services through monitoring and enforcement activities.

Home support service quality may be monitored by supervisors, through client assessments and surveys, or through case management and contract reviews. However, actual observation of worker performance requires on-site visits to clients in their homes. This poses a challenge for the effective monitoring of home support services, as some large home support agencies have more than 1,000 staff who provide service to thousands of clients, often on a daily basis. Also, since home support tasks often involve some type of personal care, such as assistance with bathing or dressing, the requirements of effective monitoring need to respect client privacy.

Role of the Ministry of Health

While the Ministry of Health plays a limited role in direct hands-on monitoring and enforcement, it does have specific legislative authority to act when the minister believes the health and safety of people receiving care is at risk. Section 8(1) of the *Continuing Care Act* permits the minister to appoint a temporary administrator to deliver home support services in place of a service provider if he or she has reasonable grounds to believe that the health or safety of people receiving care through the current service provider is at risk.

Home Support

The ministry, however, has never exercised this authority. Rather, it has delegated this responsibility, along with its other general responsibility for managing the delivery of home support services, to the health authorities. The ministry does not require the health authorities to report to it on how they carry out these delegated responsibilities.

However, one way the Ministry of Health does participate in monitoring and enforcement is through the BC Care Aide & Community Health Worker Registry, which it established in January 2010. Health authorities and publicly funded agencies, including home support agencies, are required to send the registry a written report when they suspend or terminate an employee for alleged abuse. Following receipt of such a report, the registry suspends the employee's registration until he or she has been cleared by the employer's investigation or under a process overseen by the registry. For a discussion about the BC Care Aide & Community Health Worker Registry see "Training and Qualifications for Community Health Workers" in the Home and Community Care section of this report.

Role of the Health Authorities

Health authorities are sometimes direct providers of home support services and at other times contract with and fund other agencies to provide these services on their behalf. The Ministry of Health has made the health authorities responsible for managing and monitoring the delivery of home support services, in addition to their role as service providers and funders.

The health authorities carry out their monitoring and enforcement responsibilities through various means, depending on whether they are providing services directly or have contracted with another agency to do so on their behalf.

Since April 2011, the ministry's revised *Home and Community Care Policy Manual* has included a chapter that outlines four essential components of performance management: performance standards, performance measures, reporting and quality improvement. In addition to requiring the health authorities to develop provincial performance standards in collaboration with the Ministry of Health, the policy also states that health authorities "are required to use performance data to measure and monitor improvements in quality of care and health outcomes for home and community care clients."²²³ While this policy provides a general foundation for developing a more effective system of monitoring and enforcement, it will only be useful when specific, concrete standards are developed.

Monitoring the Quality of Care Provided by Health Authority Staff and Enforcing Standards

Monitoring of the quality of care provided directly by health authority staff is carried out primarily by health authority supervisors as they fulfill their responsibility for appraising staff performance and development. The way in which services provided by health authority staff are monitored differs somewhat among health authorities.

²²³ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Performance Management: General Description, 3.A.

Home Support

Northern Health directly employs all home support workers. Currently, team leaders are responsible for overseeing service delivery and responding to any issues that arise. Vancouver Coastal Health supervisors visit home support clients regularly and monitor the performance of home support workers. In the North Shore area, supervisors are directed to visit all clients twice per year to evaluate their care plans, and to visit all home support workers four times per year in order to assess their abilities and training needs. VIHA's home support supervisors are expected to monitor indicators such as new referrals, staff immunization, scheduled hours not provided, staff turnover, and information about staff qualifications, performance plans and training. VIHA, Fraser Health and Vancouver Coastal Health conduct annual surveys of clients and families to assess their satisfaction with home support services. Interior Health did not provide us with information indicating how home support services provided by their own staff are monitored.

The health authorities rely on their human resource policies to guide them in taking corrective action when their employees are alleged to have acted inappropriately. In these circumstances, the health authorities typically conduct a performance review, which may include an investigation. If the allegations are substantiated, the health authority may provide the employee with coaching or take disciplinary steps, such as issuing warning letters or suspending or terminating the employee.

Between January 1, 2010, and March 31, 2011, Fraser Health took action against its home support staff 48 times, and Northern Health took action 46 times. Vancouver Coastal Health advised us that it took formal disciplinary action 15 times during this period, including one termination and one termination and removal from the care aide registry. Interior Health and VIHA do not track this information.

Monitoring the Quality of Care Provided by Contractors and Enforcing Standards

Health authorities use their service agreements with contracted service providers to set performance expectations and as grounds for taking corrective and enforcement actions. Although each health authority has different service agreements, the actions that can be taken in response to very serious issues of non-compliance are generally to hold back funding until a problem is satisfactorily rectified or to terminate the contract.

We reviewed service agreements between Fraser Health, Interior Health, Vancouver Coastal Health and VIHA and their contracted service providers.²²⁴ The agreements varied with regard to the monitoring and enforcement activities required of service providers, and in particular the reporting requirements. For example, service providers are required to report the following data to VIHA:

- the number of new referrals refused and the reasons why (monthly)
- immunization rates of staff (annually)
- the number of scheduled service hours not delivered due to client absence and illness (monthly)
- the number of scheduled service hours not delivered as a result of staff shortages (monthly)
- staff turnover and new hire rates (monthly)

²²⁴ The Northern Health Authority does not use contracted home support service providers.

Home Support

These data appear to be too general to shed much light on the quality of services being provided to individual clients, as did the information that Interior Health required. In comparison, Vancouver Coastal Health and Fraser Health require reports on a set of indicators that relate more directly to the way the needs of clients are being met, including:

- the average number of days between when the first home support visit is requested and when it actually occurs
- for clients with cognitive impairments, the percentage of home support visits in which they receive services from a home support worker who has skills in that area
- for palliative care clients, the percentage of home support visits in which they receive services from a home support worker who has skills in palliative care
- the percentage of home support visits in which a home support worker carries out a delegated task that is usually performed by a health professional
- the number, percentage and average waiting time of clients who meet the priority access criteria for residential care but who are supported to remain at home with home support while they wait for a bed to become available

Fraser Health and VIHA also request quarterly reports from service providers on staff training. Vancouver Coastal Health expects service providers to provide and track staff training but does not require them to report on this regularly.

We asked the health authorities to tell us the number of times they had taken corrective action against service providers. From January 1, 2010, to March 31, 2011, Vancouver Coastal Health took corrective action seven times, including two meetings to correct service concerns, one investigation of a client-related incident and four cases removed from a contracted agency due to service concerns. Fraser Health, Interior Health and VIHA did not take corrective action against a service provider during this period.²²⁵

The methods used by health authorities to monitor home support services vary considerably. Health authority employees who supervise home support workers in some cases conduct client visits at regular predetermined intervals or may review reports containing specific data related to service provision. The four health authorities that use contracted service providers require regular reports containing specific data on the home support services being provided. The data provided to Vancouver Coastal Health and Fraser Health appeared more comprehensive and directly related to the quality of care provided than the more general data that providers reported to VIHA and Interior Health. Some health authorities gather information through regular surveys of clients on their satisfaction with services. Whether service is provided by the health authority or by a service provider, regular surveys are an important method of monitoring client perspectives on services provided.

In addition to client visits, surveys and regular reports, other useful monitoring tools include file audits, complaints tracking, reportable incident reporting and inspections.

²²⁵ The Northern Health Authority does not use contracted home support service providers.

Home Support

Reportable Incidents

Unlike residential care facilities licensed under the *Community Care and Assisted Living Act* and registered as assisted living residences, home support service providers are not required by legislation or policy to report specific incidents that pose risks to clients.²²⁶ The standards published in the ministry's *Model Standards for Continuing Care and Extended Care Services* in April 1999 expect providers of continuing care services, including home support service providers, to voluntarily identify potential and actual risks through incident reporting. The examples of reportable incidents provided include elopement, security breaches, medication errors, falls and violence in the workplace.²²⁷ Although the health authorities expect their contracted service providers to comply with the model standards, none of the health authorities indicated that they monitor compliance.

Home support providers are not required by law to report incidents. The 1999 document that guides providers in this area applies to all continuing care programs, but contains no specific requirement for the reporting of specific incidents in home support services.

As noted under “Quality of Care” in this section, accredited organizations must report and follow up on events that result in a client's death or major loss of function, as well as adverse events and near misses. However, Accreditation Canada's requirements state only that reporting must comply with applicable legislation.²²⁸ This leaves a gap concerning home support services, since there are no legislative reporting requirements specific to those services. Also, while all health authorities are accredited, this is not the case for all contracted home support providers.

Our review of the health authorities' contracts with home support providers showed that their requirements for reporting incidents that affect seniors varied significantly. Both Fraser Health's and VIHA's service agreements require a provider to immediately report incidents to a designated contact within the health authority when a client is injured or harmed, whether this is the result of an act or omission by the provider or not. Service providers must also report to the health authority immediately when the health or safety of a client may be at risk. No such requirements are specified in the service agreements of Interior Health and Vancouver Coastal Health.²²⁹

²²⁶ Under the residential care model for *Community Care and Assisted Living Act* facilities, Schedule D of the *Residential Care Regulation* lists and defines 20 events, behaviours and actions that constitute a reportable incident, which operators must immediately report to the licensing office of their regional health authority, as well as to the client's family, the responsible physician and the funding body, if applicable. There is also a provincial expectation for the assisted living program to report incidents, although this is set out in policy rather than legislation and consists of a much narrower list of incidents that must be reported to the assisted living registrar by the next business day following the incident.

²²⁷ Ministry of Health and Ministry Responsible for Seniors, *Model Standards for Continuing Care and Extended Care Services*, April 1999, Organizational Functions: Risk Management, Standard 3, Criteria 3.1.

²²⁸ Accreditation Canada, Qmentum Program, *Required Organizational Practices*, February 2011, “Adverse Events Reporting,” 5.

²²⁹ The Northern Health Authority does not use contracted home support service providers.

Home Support

Incidents that may occur in the provision of home support services that should be tracked and reported promptly include medication errors, falls, instances of injury or harm, and abuse, including financial abuse and theft. Since seniors and other clients rely on home support services to remain in their homes, service providers should also report whenever a client does not receive a regularly scheduled visit because of a scheduling problem or a failure on the part of a home support worker.

It is important for home support clients throughout the province to be protected by provincial reporting requirements that identify the specific incidents that must be reported fully and promptly to the appropriate health authority and to affected clients and families. This information should in turn be monitored by the health authorities and reported at least annually to the Ministry of Health.

Inspections

Inspections of home support services may be conducted by the health authorities, the Ministry of Health or external bodies. While assisted living residences and residential care facilities can be inspected by government organizations that are not directly involved in the funding and provision of those services, such as the Office of the Assisted Living Registrar, home support services are not legally subject to inspections or audits by any similar government organization.²³⁰

The service agreements that health authorities make with their contracted service providers include the provision that health authorities be allowed to review the operations, services and records of contracted service providers. Interior Health, Vancouver Island Health and Fraser Health require contractors to allow them to periodically observe service delivery to any client, without notice, in order to assess the adequacy and quality of the service being provided. Vancouver Coastal Health has a similar requirement, although it will provide notice to its contractors prior to conducting a site visit or reviewing client files or other records. In addition to inspections conducted by health authorities, section 7 of the *Continuing Care Act* authorizes the Minister of Health to appoint inspectors for the purposes of the Act.

Currently, however, it appears that health authority site visits to home support clients may occur as part of the routine duties of contract managers and of health professionals conducting assessments. A contract manager's role is to ensure contractual compliance with the service agreement that is in place. While a health professional may identify concerns about home support services when visiting a client, his or her role is not to assess the overall quality of care, but rather to assess the client's ongoing care needs and determine the appropriate level of services required. These roles are different in both focus and intent from that of an inspector, whose primary function is to monitor the quality of care being provided to clients.

Analysis

The lack of binding provincial standards for home support adds further difficulty to the ability of health authorities to monitor home support services. In addition, monitoring home support services provided in the private homes of individual clients presents unique challenges.

²³⁰ The Community Care Licensing Branch of the Health Authorities Division has legislative authority to inspect and audit residential care services, while the Office of the Assisted Living Registrar (part of the Ministry of Health) has similar legislative authority with respect to assisted living services.

Home Support

Apart from establishing and maintaining the BC Care Aide & Community Health Worker Registry, the Ministry of Health has not taken an active role in monitoring, and delegates most of its monitoring and enforcement responsibilities to the health authorities without requiring them to report on how they carry these out.

The methods that the health authorities could use to monitor and enforce standards for home support services include conducting inspections, investigating complaints, and tracking and responding to reportable incidents. However, the lack of provincial standards for the quality of home support services and the lack of requirements regarding reportable incidents and inspections leave the health authorities with little guidance. For instance, specific reportable incidents are set out by legislation and policy for the residential care and assisted living programs but not for home support. Given this situation, it is not surprising that monitoring and enforcement practices vary widely among the health authorities.

Monitoring and enforcement activities differ depending on whether a health authority is providing services directly or through a contracted agency. When providing services directly, health authorities tend to rely on human resource policies to take action against employees who have acted inappropriately, though this may not address systemic care quality issues. When providing services through contracted agencies, health authorities retain the right to inspect or audit service providers and to withhold funding or terminate contracts. They also include reporting requirements in their service agreements with contracted agencies, but the indicators used by some of the health authorities focus on organizational efficiency and service use, not on whether the needs of individual clients are actually being met.

Health authorities also sometimes rely upon accreditation to fulfill their monitoring and enforcement responsibilities. However, not all service providers are accredited. Even if they were, there is a difference between accreditation and program standards. Binding government standards are still needed.

The Ministry of Health has not exercised its statutory power to appoint inspectors for home support. Instead, it relies on the work done by contract managers and health authority employees who are responsible for conducting client assessments to fulfill this role, as described in this section.

Two of the health authorities do not track the corrective or enforcement actions that are taken regarding home support services provided by health authority staff. Although all health authorities that use contracted agencies provided information about enforcement and corrective actions against service providers, only Vancouver Coastal Health had taken such action in the last fiscal year. The fact that there have been few enforcement actions for home support services is not surprising, given the lack of binding provincial standards or directives for home support.

Home Support

The Ombudsperson finds that

- F42. The health authorities do not have clear and consistent processes for monitoring the quality of home support services provided directly by health authority staff or by contractors, or for enforcing any applicable standards.

The Ombudsperson recommends that

- R49. The Ministry of Health work with the health authorities to establish clear and consistent processes to monitor the quality of home support services provided directly by health authority staff or by contractors, and to enforce any applicable standards.

The Ombudsperson finds that

- F43. The reporting requirements in the service agreements used by the Interior Health Authority and Vancouver Island Health Authority are too general to effectively monitor contracted home support services.

The Ombudsperson recommends that

- R50. The Interior Health Authority and Vancouver Island Health Authority adopt more specific reporting requirements in their service agreements to more effectively monitor contracted home support services.



Assisted Living

Program Overview

Description of Services

- Assisted living is a form of housing that combines private units in apartment-style residences with the provision of hospitality and prescribed care services. These services include meals, housekeeping, personal care and help with medications.
- Assisted living is meant for seniors and others who are able to direct their own care, but can no longer live safely on their own. It is usually considered to fall between home support and residential care on the spectrum of seniors' care services.
- Assisted living residences can be owned and operated by health authorities, non-profit groups or private companies.
- Individual facilities may contain only subsidized units, only non-subsidized units or both.
- Health authorities administer subsidized assisted living services, overseen by the Ministry of Health. Health authorities may provide these services directly or may contract with other organizations.
- Private companies and some non-profit groups provide non-subsidized assisted living services.

Number of People Served

- As of March 2011, there were 194 registered assisted living residences in British Columbia, containing a total of 6,832 units, the majority of them single occupancy.²³¹ Of this total, 4,380 units were subsidized while 2,452 were not.

Legislation

- Assisted living is regulated by the *Community Care and Assisted Living Act*, which also defines the powers of the assisted living registrar. The Office of the Assisted Living Registrar is an office within the Ministry of Health, and is responsible for registering assisted living residences and responding to complaints about health and safety in assisted living. The Act requires assisted living operators to register their residences and to ensure that they are operated in a manner that does not jeopardize residents' health or safety.
- The *Assisted Living Regulation* establishes the standards that operators must meet for storing and administering medication.

Cost of Providing Services

- In 2010/11, the total funding the five regional health authorities provided for assisted living was \$74.7 million. This includes the cost of both the housing and the services.
- In 2007/08, the average per unit subsidy paid by health authorities was \$55 a day, or \$1,650 per month.²³²

²³¹ Although the Office of the Assisted Living Registrar tracks the number of units, it does not track how many of these are double occupancy units.

²³² This is the most recent available information.

Assisted Living

Cost of Receiving Services

- Non-subsidized residents typically pay between \$1,500 and \$5,000 per month.
- Subsidized residents pay a maximum of 70 per cent of their after-tax income. As of March 2010, this amount ranged from \$801 to \$3,860 per month, and averaged \$1,224 per month.²³³ People who experience serious financial hardship as a result of paying the monthly rate can apply to their health authority for a hardship waiver.

Program Philosophy and History

British Columbia established its model of regulated assisted living in legislation in 2002, and began registering assisted living residences in 2004. Since then, the assisted living program has become a cornerstone of the provincial government's home and community care policy. Prior to 2004, some people who had care needs similar to those of current assisted living residents would have lived at home, perhaps while receiving home care or home support services. Those with higher care needs would have lived in a

residential care facility. Previously, residential care was provided in facilities that offered different levels of care, including personal care, levels 1, 2 and 3 of intermediate care, and extended care. However, there were few options before the introduction of assisted living for a senior who was not ready for residential care, but who also required a higher level of care than home support could provide. Assisted living is intended to fill that gap.

Assisted living is meant to provide residents with housing and services that permit a high level of independence. Services are supposed to be responsive to the residents' preferences, needs and values and to promote maximum dignity, independence and individuality.²³⁴ These principles derive from the recognition that adults, even when they need support and assistance in daily life, retain the ability and right to manage their own lives.²³⁵

Assisted living operators are responsible for unobtrusively monitoring the health and safety of residents in a supportive manner. Residents who are capable of making their own decisions are allowed to do so independently. However, where there are signs that a resident's decision

Residential care facilities and assisted living residences differ in several important ways:

Assisted Living	Residential Care
<i>Residents must be able to make decisions on their own behalf</i>	<i>Residents must require 24-hour care</i>
<i>Housing, hospitality and one or two prescribed services are provided</i>	<i>Housing, hospitality and three or more prescribed services are provided</i>
<i>The form of housing is lockable apartment-style suites</i>	<i>Residents have private or shared rooms</i>

²³³ Information provided in July 2011 by the Ministry of Health. Note that these figures include income-based rates only and do not take into account rates paid by residents receiving a government income benefit (income assistance or disability assistance).

²³⁴ Ministry of Health, "Office of the Assisted Living Registrar — About Assisted Living in BC" <<http://www.hls.gov.bc.ca/assisted/about/>>.

²³⁵ Office of the Assisted Living Registrar, *Registrant's Handbook*, August 2007, Operating an Assisted Living Residence, 2.1, 1.

Assisted Living

making abilities are deteriorating, or their decisions are threatening the health and safety of others, the operator is required to take a more active role.²³⁶ This relatively hands off approach is considered appropriate when seniors are capable of directing their own care and registering complaints.

There has been significant growth in assisted living units since the program was established in 2004. Most of this growth was achieved through involvement of the private sector, including both for-profit and non-profit agencies. As of March 31, 2011, 6 per cent of British Columbia's assisted living residences were publicly owned, with the other 94 per cent privately owned and operated.²³⁷ As of March 31, 2011, 53 per cent of privately owned and operated facilities were non-profit, while the other 47 per cent were for-profit.²³⁸

In 2010/11, 64 per cent of all assisted living units were subsidized by the provincial government. The other 36 per cent were not subsidized. Residents of non-subsidized units pay the entire cost of those units, including the attached services, using their own resources.

Table 12 – Assisted Living Residences and Units, 2004/05 to 2010/11¹

Fiscal year	Number of residences	Publicly subsidized units	Private pay units	Total units
2004/05	54	938	848	1,786
2005/06	96	2,150	1,217	3,367
2006/07	117	2,776	1,455	4,231
2007/08	150	3,618	1,617	5,235
2008/09	184	4,225	1,962	6,187
2009/10	196	4,392	2,293	6,685
2010/11	194	4,380	2,452	6,832

¹ The assisted living registrar began producing quarterly registration reports in 2005/06. The reports list registered assisted living residences by health authority, the total number of units at each residence, the number of publicly funded and private pay units for each residence and the provincial totals. Data from 2002/03 and 2003/04 were not readily available. The figure for 2008/09 includes units from applications that were already in process.

²³⁶ Office of the Assisted Living Registrar, *Registrant's Handbook*, August 2007, Operating an Assisted Living Residence, 2.2, 2.

²³⁷ Based on data from Ministry of Health, Management Information Branch, *Report 2 — Facilities and Beds by Owner Type*, 9 May 2011.

²³⁸ Based on data from Ministry of Health, Management Information Branch, *Report 2 — Facilities and Beds by Owner Type*, 9 May 2011.

Assisted Living

Table 13 – Assisted Living Residences and Units by Health Authority, 2010/11

Health authority*	Number of residences	Publicly subsidized units	Private pay units	All units
FHA	50	1,350	781	2,131
IHA	57	926	904	1,830
NHA	19	288	31	319
VCHA	24	816	393	1,209
VIHA	44	1,000	343	1,343
Totals	194	4,380	2,452	6,832

* Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

The total number of assisted living residences has increased from 54 to 194 in the past six years — an increase of 259 per cent. The number of individual units has increased from 1,786 to 6,832 — an increase of nearly 283 per cent.

Assisted Living Services

Housing is one of the key components of assisted living. Individual assisted living units are similar to apartments. They have their own bathrooms and kitchen areas and a door that can be locked. They can be bachelor suites or have one or two bedrooms that house one or two residents, typically spouses.

All assisted living operators must also provide hospitality services to the seniors who live in their residences.²³⁹ Hospitality services are defined in section 1 of the *Community Care and Assisted Living Act* as “meal services, housekeeping services, laundry services, social and recreational opportunities and a 24-hour emergency response system.”

In addition to housing and hospitality services, assisted living operators must also provide at least one but no more than two “prescribed” services. Prescribed services are defined in section 2 of the *Community Care and Assisted Living Regulation* as:

- regular assistance with activities of daily living
- central storage of medication, distribution of medication, administering medication or monitoring the taking of medication
- maintenance or management of the cash resources or other property of a resident or person in care

²³⁹ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Housing and Health Services: General Description and Definitions, 5.A.

Assisted Living

- monitoring of food intake or of adherence to therapeutic diets
- structured behaviour management and intervention
- psychosocial rehabilitative therapy or intensive physical rehabilitative therapy

Although assisted living operators can choose which one or two of these prescribed services to provide, every assisted living operator has chosen to provide the same two: assistance with daily activities and assistance with medications. Assistance with the activities of daily living includes services such as “mobilization, nutrition, lifts and transfers, cueing, bathing, grooming and toileting, as well as specific nursing and rehabilitation tasks delegated under Policy 1.C, Delegation of Tasks.”²⁴⁰

What We Heard

Since initiating this investigation, the Office of the Ombudsperson has received a variety of complaints and public input about assisted living. More specifically, we heard concerns about:

- lack of access to information about services and facilities
- unclear complaints processes
- lengthy waits for placement
- inadequate time to move into facilities
- poor quality of services provided
- unclear standards of care
- inadequate oversight
- operators failing to monitor whether seniors were still able to make decisions on their own behalf
- lack of tenancy protection for residents

The Office of the Assisted Living Registrar

Under the *Community Care and Assisted Living Act*, the assisted living registrar is responsible for administering the registration of residences and responding to complaints and concerns about the health and safety of residents. The Office of the Assisted Living Registrar (OALR) was established in November 2003. The OALR is part of the Ministry of Health and is accountable to its minister, who in turn is responsible for designating a person to be the assisted living registrar. The registrar has jurisdiction over all assisted living residences in B.C.

²⁴⁰ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Housing and Health Services: General Description and Definitions, 5.A.

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Mandate

The Ministry of Health has stated that the mandate of the Office of the Assisted Living Registrar (OALR) is “to protect the health and safety of assisted living residents” by:

- administering the registration of assisted living residences
- establishing and administering standards, policies and procedures
- receiving concerns or complaints and referring any that are not within the registrar’s jurisdiction to the appropriate authorities
- investigating complaints about the health and safety of residents living in assisted living residences²⁴¹

The registrar has jurisdiction over all assisted living residences, regardless of ownership or funding arrangements.²⁴²

Registration

The OALR is responsible for registering assisted living residences. Reviewing registration applications for assisted living residences includes the following steps:

- calling the site manager to discuss the application
- identifying any problems in the documentation filed with the application, or failures to comply with the ministry’s assisted living policies
- assessing risks and arranging for site inspections, as OALR staff consider appropriate
- following up with the applicant to address any outstanding problems²⁴³

According to the OALR, an application for registration is only approved when the operator has demonstrated a sound working knowledge of the ministry’s assisted living health and safety policies. Between 2004/05 and 2010/11, the OALR registered at least 196 assisted living residences and 194 remained registered as of March 31, 2011. However, prior to approving the registration of these residences, OALR staff visited and inspected only 21 residences. OALR staff considered pre-registration inspections appropriate for eight assisted living residences. The remaining 13 inspections were conducted but in response to complaints that facilities were operating unregistered assisted living residences. (Inspections conducted are covered in more detail later in this section under “Investigations and Inspections.”)

Funding

Funding for the OALR comes from the Ministry of Health, as well as from registration and application fees paid by operators. The application fee is \$250 per residence and the annual registration fee is \$12.40 per assisted living unit. The OALR also receives some modest revenue from the sale of registrant handbooks.

²⁴¹ Office of the Assisted Living Registrar, *Registrant Handbook*, August 2007, Introduction, 1.2.

²⁴² Ministry of Health, “Office of the Assisted Living Registrar — Mandate of the Registrar” <<http://www.health.gov.bc.ca/assisted/mandate.html>>.

²⁴³ Ministry of Health, “Office of the Assisted Living Registrar — Registering an Assisted Living Residence” <http://www.health.gov.bc.ca/assisted/ops_devs/registering.html>.

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Table 14 – Office of the Assisted Living Registrar Funding, 2004/05 to 2010/11

Fiscal year	Operating expenses (\$)	Revenue (\$)	Ministry funding (\$)	Staff, including registrar
2004/05	609,879	38,425	571,454	2.0
2005/06	447,729	45,963	401,766	2.0
2006/07	404,798	66,869	337,992	2.0
2007/08	423,155	127,990	295,165	3.0
2008/09	560,890	93,629	467,261	4.0 ¹
2009/10	573,314	36,150	537,164	4.5
2010/11	494,330	89,031	405,299	4.0

¹ In 2008/09, the number of staff was 4.5 for four months.

While the number of assisted living units more than tripled between 2004/05 and 2010/11, the office's budget was reduced by more than \$165,000, or 29 per cent, in this same period.

Staffing

The Office of the Assisted Living Registrar (OALR) currently has four full-time equivalent (FTE) employees, including the registrar. Since its creation in 2003, the office has been staffed through contracts with the Health Employers Association of BC (HEABC). The association is a registered non-profit society responsible for the human resources and labour relations interests of publicly funded health care employers, including the regional health authorities.²⁴⁴ While the Ministry of Health pays the registrar's salary directly, the HEABC pays the salaries of the OALR's other employees, and the ministry then reimburses the association for these costs.

From an administrative fairness perspective, these contractual arrangements with HEABC are a concern. The OALR is a government agency that is responsible for regulating assisted living residences, which are operated by agencies or people who are members of the HEABC. People might find it surprising that all OALR staff, with the exception of the registrar, are actually employees of the HEABC. This is not a fact that the OALR has made public. A reasonable person would question whether OALR staff are in a good position to act independently when processing applications, receiving complaints and conducting inspections of facilities that are operated by members of the same organization that employs them.

²⁴⁴ For more information: <http://www.heabc.bc.ca>.

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The Ombudsperson finds that

- F44. The Ministry of Health's practice of contracting with the Health Employers Association of BC to staff the Office of the Assisted Living Registrar is incompatible with the role of that office as an impartial overseer of assisted living.

The Ombudsperson recommends that

- R51. The Ministry of Health stop contracting with the Health Employers Association of BC to staff the Office of the Assisted Living Registrar and instead staff all positions with permanent employees of the ministry.

Powers of the Assisted Living Registrar

Under the *Community Care and Assisted Living Act*, the registrar may register an assisted living residence if satisfied that the services provided in that residence will not jeopardize the residents' health or safety.

If the registrar has reason to believe that an assisted living residence is operating without being registered, or that the health and safety of a resident is at risk, the registrar may enter and inspect the premises, inspect and make a copy of any records found there, make a record of anything observed during an inspection or apply to a justice for a warrant to enter and inspect a private single-family dwelling.²⁴⁵ In practice, however, OALR staff members rather than the registrar are investigating complaints and conducting investigations. While the Act allows the registrar to delegate her powers to staff so that they can enter and inspect residences, the registrar has not done so, aside from temporary delegations to cover absences. As a result, OALR staff have been exercising the registrar's investigative powers without the authority to do so.

In addition to entering and inspecting residences, the registrar may suspend or cancel a registration, attach conditions to a registration, or vary the conditions of registration if she believes that an operator is not complying with the Act or regulations, or has contravened another Act or a condition of the registration.²⁴⁶

The Act allows an operator or applicant for registration to challenge these decisions to the registrar. Once the registrar makes her final decision, she must provide further written reasons for that decision to the operator or applicant. An operator or applicant for registration can appeal the registrar's decision to the Community Care and Assisted Living Appeal Board, but must do so within 30 days.²⁴⁷

²⁴⁵ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, s. 25.

²⁴⁶ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, s. 27.

²⁴⁷ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, s. 29(2)(c).

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The Ombudsperson finds that

F45. The assisted living registrar has not delegated the investigative powers she has under the *Community Care and Assisted Living Act* to her staff.

The Ombudsperson recommends that

R52. The assisted living registrar delegate the investigative powers she has under the *Community Care and Assisted Living Act* to any of her staff who require those powers.

Independent Living BC

During the course of our investigation, we found that a number of people were confused about the relationship between the provincial program called Independent Living BC (ILBC) and assisted living housing and services, and about the use of the term “independent living.”

Independent Living BC (ILBC) is a program the provincial government created in 2001 that funds the development of new assisted living units. The program is delivered by BC Housing, in partnership with the health authorities, Canada Mortgage and Housing Corporation, and for-profit and non-profit operators. When it was first established, the program’s purpose was to create 3,500 assisted living units. Currently, the ILBC provides funding for what is designated as the subsidized housing aspect of assisted living, while the health authorities fund what are designated as personal services.

As discussed, assisted living is a form of housing that combines private apartment-style units with the provision of hospitality and prescribed care services. Assisted living residences are regulated by the *Community Care and Assisted Living Act* and must be registered with the Office of the Assisted Living Registrar.

The provincial government, health authorities and the public also use the term “independent living” to describe a number of different housing options, including private retirement homes and active living housing complexes designed for seniors. We have observed that the different ways that this term is used can create confusion, even to the extent that some people may think their “independent living” residence is under the jurisdiction of the OALR, when in fact they are living in an unregulated retirement home. (Further information on these terms can be found under “Community-Based Programs” in the Background section of this report.)

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Funding Assisted Living

As set out earlier in this report, the Ministry of Health decides the total amount of funding that each health authority will receive at the beginning of each fiscal year.

Once informed of an overall budget, each health authority then determines how to allocate the funds to meet its service obligations. These obligations include hospital services, mental health, home and community care services, public health protection, and environmental health. Each health authority budget since 2002/03 has included funding for assisted living within the overall home and community care budget.

The health authorities told us that they decide how much funding to assign to assisted living by considering what was spent on this program during the previous year, as well as by predicting population and health status changes, program and service changes, the introduction of new policies by the ministry or other bodies, and the potential for increased costs.

The health authorities told us that their decisions on funding for assisted living between 2001 and 2009 were significantly influenced by the targets set by the Ministry of Health, including the ministry's goal of creating 5,000 new beds for seniors.

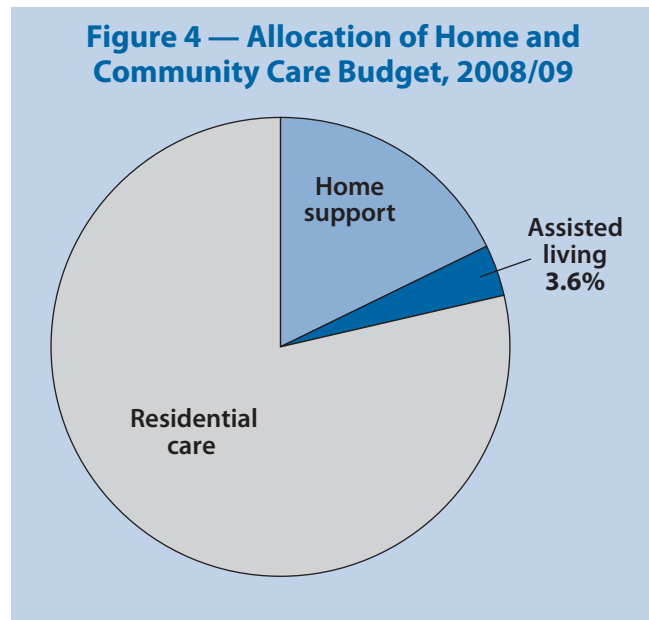


Table 15 — Health Authority Funding for Assisted Living, 2002/03 to 2010/11

Fiscal Year	FHA* (\$)	IHA ¹ (\$)	NHA (\$)	VCHA (\$)	VIHA (\$)	Provincial totals (\$)
2002/03	1,588,000	511,390	Not available	589,914	0	Not available
2003/04	1,779,000	1,970,875	Not available	3,032,155	50,457	Not available
2004/05	4,804,000	5,015,156	781,363	4,582,438	2,658,942	17,841,899
2005/06	8,063,000	9,626,136	1,279,282	5,695,202	3,701,073	27,735,646
2006/07	15,299,000	16,157,933	1,897,942	9,490,860	4,900,816	47,746,551
2007/08	20,191,000	18,849,399	3,380,355	12,195,563	6,436,303	61,052,620
2008/09	23,513,000	21,173,751	4,303,122	14,942,998	7,494,374	71,711,794
2009/10	23,500,000	20,156,858	5,525,478	15,437,573	7,923,955	72,543,864
2010/11	23,009,887	20,845,193	7,341,802	15,986,269	7,540,231	74,723,382

* Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

¹ The IHA figures include funding for the Choice in Supports for Independent Living (CSIL) program as well as short-term home support services.

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As the table above shows, the overall health authorities' funding totals for assisted living have grown each year since 2004/05, although only the Northern Health Authority and Vancouver Coastal Health Authority report a funding increase every year. Since 2002/03, funding for assisted living has increased to the point that in 2009/10 it represented close to 4 per cent of the home and community care budget. In 2010/11, the health authorities allocated more than \$70 million for assisted living services.

Clearly, it should be important that the Ministry of Health and the health authorities monitor the demand for subsidized assisted living, so that they are able to plan for future funding needs and ensure that those who are currently eligible are able to access services in a timely manner. We asked the Ministry of Health and the health authorities how they determined whether the funding provided is sufficient to meet the demand for subsidized assisted living. Neither the Ministry of Health nor the health authorities were able to provide us with any information indicating that they monitor the demand for subsidized assisted living services to determine whether the funding provided is sufficient. This poses challenges to the Ministry of Health's ability to fulfill its role of evaluating whether the system has the capacity to meet the needs of B.C.'s seniors.

The average daily cost to health authorities for a subsidized assisted living unit is \$55 per day or \$1,650 per month. This is equivalent to approximately 1.5 hours of home support a day.

Source: Ministry of Health, Assisted Living Fact Sheet, May 2008, 4.

In October 2008, the Office of the Auditor General of British Columbia released its report *Home and Community Care Services: Meeting Needs and Preparing for the Future*.²⁴⁸ The Auditor General examined whether the Ministry of Health was acting as an effective steward by ensuring that the home and community care system has the capacity to meet the needs of British Columbia's residents, both now and in the future. The Auditor General concluded that the ministry did not have a comprehensive planning framework for home and community care and recommended that it expand its planning and analytical tools in a number of key ways (Further information about the Auditor General's report can be found under "Funding" in the Home and Community Care section of this report.)

Enhanced transparency would help identify how this growing area of home and community care is being funded and what services are being provided. As recommended in the Home and Community Care section of this report, the Ministry of Health should also publicly report on the forecasted budget and money actually spent on assisted living services by each of the health authorities annually.

Cost of Receiving Services

Seniors who do not qualify for a subsidy, or who choose not to apply for one, typically pay between \$1,500 and \$5,000 per month to live in an assisted living residence and receive the services provided there. Seniors who are eligible for a subsidy pay a maximum of 70 per cent of their after-tax income, unless that figure

²⁴⁸ Office of the Auditor General of British Columbia, *Home and Community Care Services: Meeting Needs and Preparing for the Future*, October 2008.

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exceeds the actual cost of the service.²⁴⁹ In March 2010, the average rate that British Columbia seniors paid to live in a publicly subsidized assisted living unit, including the cost of receiving hospitality and personal care services, was \$1,224 per month.

Seniors whose only income comes from Old Age Security payments and the Guaranteed Income Supplement have annual gross incomes of approximately \$14,300 and pay a maximum of \$835 per month to live in a subsidized assisted living unit and to receive the housing, hospitality and personal care services provided there. This leaves the senior with approximately \$357 per month to cover other living expenses (phone, cable, activities, transport, travel, gifts, etc.).

The health professionals who are tasked by the health authorities with conducting assessments calculate the monthly rate each person will pay, based on that person's tax return from the previous year. This is done when each senior first applies for service. The Ministry of Health then recalculates these rates each fall, based on information in the databases of the Canada Revenue Agency (CRA) and Guaranteed Income Supplement (GIS) program. Health authorities notify clients by letter if their rate will change as result of this recalculation and the new rate takes effect January 1 of the following year.

Anyone who experiences serious financial hardship as a result of paying the assessed monthly rate can apply to the health authority for a hardship waiver. (For a discussion of financial hardship and fee reductions, see "Fees and Fee Waivers" in the Home and Community Care section of this report.)

Between August 2008 (when we began our investigation) and April 2011, we noticed that there was no ministry policy regarding which items and services should be included in the assessed client rate for assisted living, and which ones could be subject to an extra charge. The revised *Home and Community*

Care Policy Manual that took effect on April 1, 2011, includes a new "Benefits and Allowable Charges" section that lists what must be offered to all assisted living clients at no additional charge over and above the assessed client rate:

- a private housing unit with a lockable door
- personal care services
- two nutritious meals per day, one of which is the main meal
- access to basic activity programming
- weekly housekeeping
- laundering of towels and linens
- access to laundry equipment for personal laundry
- heating or air conditioning as necessary to maintain the safety and basic comfort level of the residence
- a 24-hour emergency response system

²⁴⁹ The rate that any senior pays will not exceed the combined cost of the market rate for housing and hospitality services in their geographic area and the actual cost of personal care services. Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Rates: Income-Based Client Rates, 7.B.2.

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The section also lists “allowable charges” and “chargeable items.” Allowable charges include a surcharge for hydro services and a one-time damage deposit, which must be listed in the client’s residency agreement. Chargeable items include extras such as a cable connection, personal telephone connection, guest meals, personal grooming services and special outings or events. According to the manual, service providers who offer chargeable items must do so at or below market rates and only on an optional basis.²⁵⁰

The inclusion of these requirements in the manual is an important step toward ensuring that assisted living residents across the province are charged in a similar manner for similar services, and that no residents are charged extra for services that are included in their assessed rate.

However, although these “benefits” are identified as included in the assessed client rate, the ministry has told health authorities and assisted living operators that they have until April 1, 2013, to comply with this policy. That means that assisted living residents may be “double billed” for some benefits until the policy comes into force. It is unfair and unreasonable for the ministry to delay the implementation of this policy until April 1, 2013.

The Ombudsperson finds that

F46. It is unfair and unreasonable for the Ministry of Health to give health authorities and facility operators until April 1, 2013, to comply with its policy on benefits and allowable charges in assisted living because this allows operators to charge fees for benefits that are included in the assessed client rate.

The Ombudsperson recommends that

R53. The Ministry of Health require health authorities and assisted living operators to comply with its policy on benefits and allowable charges immediately rather than by April 1, 2013. If this results in an unexpected financial inequity for certain operators, the ministry take steps to resolve this inequity in a fair and reasonable manner.

The Legal Definition of Assisted Living

According to section 1 of the *Community Care and Assisted Living Act*, “assisted living residences” can provide no more than two prescribed services. These services are listed in the *Community Care and Assisted Living Regulation*. Operators can choose whether to provide one or two of the prescribed services. A residence that offers three or more prescribed services must be licensed as a residential care facility.²⁵¹ The licensing process for such a facility is considerably more involved and rigorous than the registration process for an assisted living residence. Residential care facilities are also more stringently monitored than assisted living residences.

²⁵⁰ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Housing and Health Services: Assisted Living Services, 5.B.3.

²⁵¹ Residential care is provided in a community care facility that is defined in section 1 of the *Community Care and Assisted Living Act* as a premise or a part of a premise where care is provided to three or more unrelated people or is designated by cabinet to be a community care facility. Care is defined as supervision that is provided to an adult who is vulnerable because of family circumstances, age, disability, illness or frailty and dependent on caregivers for continuing services in the form of three or more prescribed services.

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Operators sometimes find it challenging to provide useful and appropriate services in an assisted living residence as defined in the *Community Care and Assisted Living Act*. In the consultations and meetings we conducted as part of this investigation, we learned about what is described as a “grey area” between assisted living and residential care. People who fall into this grey area include residents whose medical needs exceed the services that assisted living operators can legally provide, and residents who can no longer make their own decisions and do not have a spouse to do so for them. Another group that falls into this category is residents who are awaiting placement in residential care because they require additional services to meet their needs. These residents may be in this grey area for prolonged periods, if there is a lack of available residential care beds. In other cases, residents may want operators to provide them with additional services so they can remain in their assisted living unit as long as possible and avoid moving into residential care.

Residents in the grey area may want or need additional services so that they can continue to live safely in assisted living. However, the *Community Care and Assisted Living Act* restricts the number of services that operators are allowed to provide.

The Ministry of Health’s Policy on Providing Prescribed Services at the Support Level

In August 2007, the Ministry of Health developed a policy that appears to be aimed at addressing the difficulty that operators experience when trying to provide additional services in accord with the legal definition of an assisted living residence. This policy allows operators to provide more than two prescribed services by distinguishing between those provided at the “prescribed level” and those provided at what the ministry calls the “support level,” which is described as “less intensive.”²⁵² As a result of the development of this policy, the ministry now allows operators to offer any number of the prescribed services that are listed in section 2 of the *Community Care and Assisted Living Regulation* at a so-called support level. In a letter to our office, the registrar explained the distinction the ministry has created:

The terms *support level* and *prescribed level* come from policy. These terms are used to distinguish the degrees of intensity with which an operator can offer a prescribed service. The statutory definition of assisted living residence allows operators to offer only one or two prescribed services, which through policy is interpreted to mean offering the services at the prescribed level. Offering one or two services at the prescribed level triggers the requirement to apply for registration. Operators may also offer less intensive assistance in the other prescribed service areas.²⁵³

One example of a prescribed service is monitoring the food intake of an assisted living resident. The following table sets out how the ministry has described the provision of this service when it is offered at the prescribed level versus the support level.

²⁵² Office of the Assisted Living Registrar, *Registrant Handbook*, August 2007, Personal Assistance Services, 6.2.

²⁵³ Office of the Assisted Living Registrar, letter to the Office of the Ombudsperson, 8 June 2009.

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Table 16 – Prescribed Level and Support Level for Monitoring Food Intake or Therapeutic Diets¹

Prescribed level	Support level
Monitor/measure/record food/fluid intake	Monitor food consumption for purposes of satisfaction and quality control
Determine and chart residents' weights on a regular and/or compulsory basis	Operator may provide a voluntary program for residents to weigh-in or weigh a resident upon their request
Provide expertise to assess a resident's health/nutritional status and implement a special or therapeutic diet	Modify meals in accordance with diets requested by residents and as recommended and monitored by the resident's dietician or physician
Observe/report whether resident complies with special or therapeutic diet	Observe changes in eating habits and bring changes of concern to resident's or other's attention

¹ Office of the Assisted Living Registrar, *Registrant Handbook*, August 2007, Policy 10, Appendix 1.

As the table shows, the difference between providing service at the prescribed level and the new support level is not always obvious.

The ministry's desire to allow operators to provide a broader range of assisted living services may indicate the need for a more flexible statutory framework. However, a policy that distinguishes between services offered at the prescribed level and those offered at the support level has the effect of allowing facilities to offer more than two prescribed services, which contravenes the *Community Care and Assisted Living Regulation*. The ministry does not have the legal authority to expand the legislated definition of assisted living residence by creating new policy.

The *Community Care and Assisted Living Act* defines an assisted living residence as one that offers one or two prescribed services, and does not permit offering additional services "at a lower intensity." If a residence offers one or two of these services, it must be registered. According to the Act, it cannot qualify as an assisted living residence if it offers three or more prescribed services. The Act empowers cabinet alone to prescribe the services that qualify an assisted living residence for registration, and cabinet has done so in the *Community Care and Assisted Living Regulation*.

In addition, while medical health officers have authority under the *Community Care and Assisted Living Act* to exempt residential care facility operators or applicants for a licence from many provisions of the Act or its Regulation, section 3 of the Regulation specifically states that medical health officers cannot exempt assisted living facility operators from the requirement that they provide only one or two prescribed services. This is consistent with cabinet alone having the power under the Act to prescribe the services assisted living operators offer.

Equally important, the OALR does not require assisted living facility operators to report which services they are offering at the support level. The ministry, therefore, has no idea how many facilities are offering services at this level, which services they are offering or even whether facilities are operating properly within the support level guidelines. According to the ministry, it does not have jurisdiction to investigate complaints that a residence is offering more than two prescribed services. It forwards any complaints it receives of this

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nature to community care licensing offices for investigation.²⁵⁴ If the licensing officer's investigation confirms that more than two prescribed services are being offered, then it is the licensing office that can require the facility to apply for a licence to operate a residential care facility or discontinue the extra prescribed services that are being provided. The ministry's policy of allowing operators to offer more than two prescribed services if they are provided at the support level appears to conflict with the legislated duties of medical health officers.

Analysis

The provincial government created the current model of assisted living in 2002 when it enacted the *Community Care and Assisted Living Act*. The Act recognizes that assisted living residents are less frail and more independent than seniors who need residential care, and thus requires less oversight for assisted living residences than for residential care facilities. Because assisted living residences and residential care facilities are subject to different levels of oversight, it is important to distinguish between these two types of facilities. Without a clear boundary, people who should be in residential care can end up in assisted living residences that are not subject to the licensing provisions of residential care. The Act sets this boundary by defining an assisted living residence as a facility that provides housing, hospitality services and at least one but no more than two prescribed services. If a facility provides more than two prescribed services, it must be licensed as a residential care facility, which means being subject to the same more rigorous standards and oversight as a residential care facility. The *Community Care and Assisted Living Regulation* states that a medical health officer cannot exempt a facility from the limit on prescribed services.

Current policy and practice do not reflect this distinction. The OALR told us it has found that strictly confining operators to the provision of two prescribed services limits their ability to meet the care needs of residents. Responding to this difficulty, the ministry has created a policy that allows operators to provide additional prescribed services “at a lower intensity.” In effect, the ministry has weakened the distinction between assisted living residences and residential care facilities. This is a problem because the level of oversight that residential care facilities are subject to corresponds to the needs and vulnerabilities of the seniors served in these facilities. A high level of oversight is appropriate and necessary to protect people whose care needs make them vulnerable. Permitting assisted living residences to house seniors with higher-level care needs while not protecting them with a higher level of oversight is an unofficial shift in practice that should concern policy-makers, as well as seniors and their families.

Since the Act came into effect in 2004, every operator has chosen to offer the same two prescribed services. The ministry's decision to expand the number of services that operators can offer may indicate that the model of assisted living is not meeting the needs of residents, or that the needs of assisted living residents are changing, or both. This is an issue worthy of further consideration. The Ministry of Health should review the provisions of the *Community Care and Assisted Living Act* that apply to assisted living operators and residences to ensure they meet the needs of assisted living residents. If the ministry decides to allow operators to provide more than two prescribed services to meet a wider range of care needs, the ministry should take steps to amend the Act's definition of an “assisted living residence” and enact legislated standards and requirements that are appropriate for the new level of care.

²⁵⁴ Ministry of Health, “Office of the Assisted Living Registrar — Complaint Investigation” <<http://www.health.gov.bc.ca/assisted/complaints.html#jurisdiction>>.

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The Ombudsperson finds that

- F47. There is no statutory basis for the Ministry of Health's practice of allowing operators to provide prescribed services at the support level.

The Ombudsperson recommends that

- R54. If the Ministry of Health believes that the practice of allowing operators to provide prescribed services at the support level is useful, the ministry take steps to revise the definition of "assisted living residence" in the *Community Care and Assisted Living Act*, so that it provides a statutory basis for doing so.
- R55. If the Ministry of Health decides to revise the definition of "assisted living residence" in the *Community Care and Assisted Living Act* it ensure that any changes in service delivery practices maintain a clear distinction between the services provided in assisted living residences and those provided in residential care facilities.
- R56. If the Ministry of Health decides to revise the definition of "assisted living residence" in the *Community Care and Assisted Living Act* to allow operators to provide additional services, it ensure this is accompanied by increased oversight, monitoring and enforcement.

Availability of Information

Clear, accessible and comparable information helps seniors and their caregivers understand the services that are available to them and the differences between them. Having access to this information is important because once seniors have been determined eligible for placement in a subsidized assisted living unit, they are then given the opportunity to identify a preferred facility or location.²⁵⁵

"I have spent hours online trying to find out what the difference is between assisted living and independent living."

Source: Respondent, Ombudsperson's questionnaire.

Home and Community Care Directive

In February 2009, the former Minister of Health Services sent a directive to each of the five health authorities that required them to make the following information about facilities in their region (including assisted living residences) available to the public in a prescribed format:

- addresses and contact information
- the number of publicly funded beds
- current services and activities
- philosophy of care
- accreditation status

²⁵⁵ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Housing and Health Services: Assisted Living Services, 5.B.2.

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- restrictions or rules
- language
- cultural and religious affiliation, if applicable
- any additional amenities²⁵⁶

The minister also directed the health authorities to provide public information on how to access community programs and facility-based care, intake and screening processes, and to ensure the public knows how to complain about home and community care services. The directive also required information to be provided about the health authority's progress on ensuring quality standards of care. The ministry informed us that the health authorities were working on revisions to their websites and that it expected the new information to be available on the websites by October 31, 2010.

Our office has monitored the implementation of this directive since it was issued. While the health authorities have made considerable progress, more than two years after the directive was issued, the health authorities have not yet fully complied with all the directive's requirements. The ministry has also supplemented the directive by including a requirement that "clients must be provided with information on assisted living options, and the health authority's process for managing access to assisted living services" in its revised *Home and Community Care Policy Manual* effective April 1, 2011.

While all the health authority websites include general information about access, eligibility and intake, they vary considerably in the information provided about complaints. (For further discussion, see "Complaints" later in this section.) The health authorities have updated their websites to provide some of the facility-specific information set out in the minister's directive. However, information for many assisted living residences is incomplete. For example, in our review of health authority websites, we did not find information about the accreditation status of assisted living residences.²⁵⁷ Also, the Fraser Health Authority and Vancouver Coastal Health Authority did not provide a philosophy of care for assisted living residences. As well, Vancouver Coastal Health did not specify the ownership status of each assisted living residence in its region.

In the *Best of Care (Part 1)* we focused on residential care and highlighted the importance of access to useful information for seniors and their families who are making critical decisions about their care. While seniors who are considering a move to assisted living are not generally as frail or as vulnerable as those considering residential care, they still have greater care needs than the average adult, and are being called upon to make a significant life decision in a limited amount of time.

Best Practice – Vancouver Island Health Authority

The website for the Vancouver Island Health Authority contains detailed, facility-specific information on its assisted living services. In addition, VIHA has created a tenant handbook that clearly explains assisted living, and provides guidance for those deciding whether assisted living is the right option.

The handbook has been adapted for use by Vancouver Coastal Health, and has also been made available on the OALR website.

Source: Vancouver Island Health Authority website <<http://www.viha.ca/hcc/assisted>>.

²⁵⁶ Ministry of Health directive, February 2009.

²⁵⁷ Some assisted living operators have been awarded a Seal of Approval through the BC Seniors Living Association.

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Because these seniors need comprehensive information about the various facility options, we believe that in addition to the information required by the minister's directive, health authority websites should include the following:

- the basic services available at each assisted living facility in the region and their costs, as well as the type and costs of any other services available at each facility
- billing processes for each assisted living residence in the region
- the care policies and standards for each assisted living residence in the region
- the complaints process for each assisted living residence in the region

Ministry of Health and Office of the Assisted Living Registrar Websites

The websites for the Ministry of Health and Office of the Assisted Living Registrar (OALR) provide useful information about the eligibility requirements for assisted living, the application process and costs. The OALR website includes clear information outlining the complaints process and a residence locator tool that is easy to use. However, details about specific residences are limited to contact information and the number of units.

The Ombudsperson finds that

- F48. The health authorities have not yet fully complied with the February 2009 Minister of Health's directive that requires them to make specific information about assisted living publicly available.

The Ombudsperson recommends that

- R57. The health authorities fully comply with the February 2009 Minister of Health's directive immediately.

The Ombudsperson finds that

- F49. The Ministry of Health has not ensured that adequate information is publicly available in an accessible format that allows seniors and their families to plan and make informed decisions about assisted living.

The Ombudsperson recommends that

- R58. The Ministry of Health ensure the health authorities make the following additional information available to the public by June 1, 2012:
- the basic services available at each assisted living facility in their region and their costs, as well as the type and costs of any other services available at each facility
 - billing processes for each assisted living residence in their region
 - the care policies and standards for each assisted living residence in their region

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Eligibility and Assessment

To be eligible for publicly subsidized assisted living, a person must be assessed by a health professional in a health authority as:

- requiring both hospitality and personal care services
- able to make decisions that will allow him or her to function safely in an assisted living residence, or living with a spouse who is willing and able to make those decisions
- at significant risk in his or her current living environment (for example, because of a history of falls, isolation or poor nutrition)²⁵⁸

Agreeing to pay all applicable costs is also a condition of eligibility for subsidized assisted living services.

Since it is common for seniors' abilities and care needs to change, it is important that assessment processes be ongoing to ensure that seniors continue to receive the appropriate level of care.

Seniors who can afford to do so may instead apply to live in a non-subsidized assisted living residence, in which case, they do not need to be assessed by a health professional in a health authority. However, eligibility for both subsidized and non-subsidized assisted living requires residents to be able to make decisions on their own behalf.

During our investigation, seniors and advocacy groups told us that they were concerned about situations in which assisted living operators continued to house seniors in their residences, even when they were no longer eligible to be there because they were unable to make their own decisions. We also heard of seniors who were reluctant to leave their familiar homes in assisted living residences, even though they were in need of more care than could be provided in those settings.

Section 26(3) of the *Community Care and Assisted Living Act*

Section 26(3) of the *Community Care and Assisted Living Act* specifies that assisted living operators must not house people who are “unable to make decisions on their own behalf.” This means operators must not admit applicants who are incapable of making their own decisions and that operators must regularly assess residents' capability to do so. If a resident is not able to make such decisions, section 26(3) requires operators to initiate the exit process.

Legally, adults are presumed to be capable of making their own decisions unless there is evidence to the contrary. The Act does not list or define the type of decisions residents must be able to make, nor does the Act establish a process for evaluation, assessment and appeal or review of decisions made about someone's capability to make decisions on his or her own behalf.

In the absence of such details, the Ministry of Health has created a policy to guide decision-makers in the application of section 26(3).²⁵⁹ The policy requires that residents be able “to make the range of decisions necessary to function safely in an assisted living setting.” This includes the ability of residents to:

²⁵⁸ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Housing and Health Services: Assisted Living Services, 5.B.1.

²⁵⁹ Office of the Assisted Living Registrar, *Registrant Handbook*, August 2007, Resident Entry and Exit, 5.3.

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- initiate activities necessary to function safely while alone in their unit
- find their way in their assisted living residence
- recognize consequences of decisions and actions
- recognize an emergency
- find their way back to their residence independently
- participate in reviews of service needs
- make a complaint about services

In the absence of a legal definition or test, decision-makers may choose to use ministry policy to guide their application of section 26(3), but are not required to do so.

The Role of Assisted Living Operators

Assisted living operators are responsible for managing entry to and exit from assisted living residences. Where the resident is entering or exiting subsidized assisted living, the operator works together with the senior's case manager to manage the process.

The Ministry of Health's entry policy states that unless there are signs to the contrary, operators should presume that applicants are able to make decisions and function safely in an assisted living residence.²⁶⁰ The policy directs operators to screen applicants during a pre-entry interview to ensure that they are able to make an informed decision to enter the residence and are also able to function safely there. During the application process, operators are supposed to explain their legal obligation not to house people who are unable to make their own decisions and to inform applicants that they will need to seek alternate accommodations if they are unable to do so.

Assisted living is considered inappropriate for an applicant if a court has determined that the person is not able to make personal care decisions and has appointed a committee of person, or may be inappropriate if a health care representation agreement has been enacted. Further inquiry is needed if the person has signed a section 7 health care representation agreement or granted a power of attorney, as well as if a temporary substitute decision-maker is regularly making health care decisions for the person, or if the court has appointed a committee of estate to manage the person's financial and legal affairs.²⁶¹ The extent to which operators undertake this further inquiry is unclear. We learned during the course of our investigation that the public guardian and trustee manages the financial and legal affairs of some assisted living residents.

If an operator is made aware of such conditions or observes signs during the entry process that an applicant may not be able to make decisions on his or her own behalf, ministry policy indicates that the operator should ask the applicant (or the applicant's contact person or representative) to have a doctor or health professional conduct a medical evaluation. The operator is then supposed to consider this evaluation when deciding whether to admit the applicant.

²⁶⁰ Office of the Assisted Living Registrar, *Registrant Handbook*, August 2007, Resident Entry and Exit, 5.3.

²⁶¹ A section 7 health care representation agreement is made pursuant to the *Representation Agreement Act*, R.S.B.C. 1996, c. 405, s. 7.

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Operators are also expected to ensure that they do not house people who cannot make their own decisions by monitoring the capabilities of residents on an ongoing basis. In both subsidized and non-subsidized assisted living residences, operators and their staff should be watching for signs that residents are unable to make decisions. These signs include a decline in functional ability and changes in behaviour, habits, general appearance, social patterns, living conditions or overall health.²⁶² The Office of the Assisted Living Registrar (OALR) policy states that operators should have policies and procedures to guide staff in observing, documenting and reporting changes in residents' behaviour.

If operators or their staff do see signs that a resident is no longer capable of functioning safely in assisted living, the operator should raise these concerns with the resident and contact person. It is then the responsibility of the resident or contact person to get a doctor or other health professional to conduct a medical evaluation. If this does not happen, the operator will consider whether to notify the resident that he or she must move out and ask the resident (or the resident's contact person or representative or a case manager) to find another place to live. Operators in this situation should develop an exit plan for the resident that includes relocation arrangements and information about the additional services needed by the resident that will be available until a move is possible.

It is important to note that while an assessment of decision-making capacity may be conducted by a doctor or other health professional, facility operators are responsible under section 26(3) of the *Community Care and Assisted Living Act* for determining whether a person is capable, and that this is an administrative decision made after considering the facts and the law. Operators consider the opinion of health professionals, but the final decision about eligibility for assisted living is made by the facility operator.

The Act does not establish a process for residents or family members to challenge or review an operator's decision about a resident or potential resident's ability to make decisions on his or her own behalf. However, operators may discuss a decision with the resident and his or her family. When agreement is not possible, ministry policy says operators can continue with the exit process, which will result in an eviction. It is important to note that assisted living residents, unlike other tenants, are not covered by the *Residential Tenancy Act* and cannot use its provisions to dispute an eviction. (This is discussed under "Complaints about Tenancy Issues" later in this section.)

The Limited Role of Health Professionals

Health professionals who work for health authorities play a role in assessing seniors' initial and continued eligibility for subsidized assisted living, but do not play this role for seniors in non-subsidized assisted living units because the private operators of these residences make decisions about eligibility.²⁶³

According to ministry policy, subsidized assisted living applicants are to be assessed by a health professional using the interRAI screening tool provided by the health authority. If the health professional sees signs that an applicant is not able to make the decisions necessary to function in assisted living, the health professional should consult with the applicant's family, doctor and other caregivers, seek a geriatric or psychiatric

²⁶² Office of the Assisted Living Registrar, *Registrant Handbook*, August 2007, Resident Entry and Exit, 5.3.

²⁶³ Home and community care services are available and provided to people in private assisted living, including community nursing, rehabilitation and home support.

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consultation if necessary, or request that the mental health outreach team investigate a specific issue or concern. If after these additional consultations have taken place the health professional concludes that the applicant cannot make his or her own decisions, the applicant should not be referred to assisted living.

Health professionals may also reassess subsidized assisted living residents on an ongoing basis and when operators or family members report changes in behaviour. If health professionals observe changes, they are supposed to notify facility operators. The Ministry of Health's policy requires health professionals in the health authorities to reassess an assisted living resident's health and care plan when:

- the resident's health condition and/or personal living circumstances are considered unstable during the initial assessment
- the health authority has reason to believe that the resident's and/or caregiver's situation has changed
- reassessment is requested by the family physician, client, caregivers or health professionals based on specific concerns
- not more than one year has passed since the last assessment, and other indicators of a need for reassessment have not been received²⁶⁴

Analysis

Section 26(3) of the *Community Care and Assisted Living Act* states that operators must not house people who are "unable to make decisions on their own behalf." When this important assessment of decision-making capacity is made by an operator, it determines whether an applicant is permitted to move into assisted living, or whether an assisted living resident must move out. We therefore expected to find a clear, consistent and fair process for making such a decision under section 26(3) that included an opportunity to be heard and for people who disagree with the decision to challenge it through an independent review or appeal process. Instead, we found that the Act does not set out what legal test should be applied, what process should be followed in making the decision, or what additional consequences may result.

The Ministry of Health has created policy that provides some guidance for facility operators and health professionals regarding section 26(3), but the policy does not have the force of law. The ministry has interpreted section 26(3) to mean that a facility operator cannot house a resident who is unable to make the range of decisions necessary to function safely in an assisted living residence, and has further specified the types of decisions this includes in its policy. The policy also provides a process by which decisions under section 26(3) should be made. According to the policy, if an operator or a health professional sees signs that a resident is no longer able to make decisions, the operator or health professional should direct the resident, or the resident's representative, to obtain a medical evaluation. The operator should then consider this evaluation when determining whether the resident is able to make his or her own decisions.

Because the Act does not indicate how operators are to determine the decision-making capacity of residents, the ministry expects operators to rely on the interpretation of section 26(3) outlined in its policy. This policy indicates that operators should use medical evaluations to inform their decisions, but that such evaluations are not the only factor to be considered. According to this approach, an operator's decision under section 26(3) should involve a wider consideration of each resident's abilities and circumstances.

²⁶⁴ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Assessment, 2.D.

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When an assisted living operator decides that a resident is unable to make decisions on his or her own behalf, this will likely result in that person having to move to another care setting, and may have serious consequences. For example, if a resident is required to leave assisted living, the resident may need to be cared for in a residential care facility. Admission to residential care requires the consent of the senior or his or her legal representative. However, if a person is identified as unable to make the decisions necessary to function safely in assisted living, it reasonably raises questions about whether that person can make other personal and health care decisions.

Given the significant impact of the medical evaluation and the operator's administrative decision, both should follow a defined, standard and legally binding process that provides protection for the residents' interests. The ministry should set out in regulation:

- the training and qualifications required to perform the medical evaluation
- who may perform the evaluation
- how the evaluation should be performed and what should be considered
- the requirement to inform residents of the purpose of the evaluation and its consequences
- the requirement to inform residents of their right to consent to or refuse the evaluation
- the requirement to inform residents that they may have a representative present during the evaluation
- the requirement to keep a written record of the evaluation
- an independent process for reviewing the evaluation

The ministry should also define the process for operators to follow and the factors to consider when determining decision-making capacity under section 26(3) of the Act. This process should include gathering input from the resident or the resident's representative, and should result in a written decision that informs the resident or representative of the rules that were applied and the information that was considered before making the decision.

A decision made under section 26(3) of the *Community Care and Assisted Living Act* can have significant consequences for residents, including eviction from their assisted living unit. In some cases, operators may have a financial interest in the outcome of the decisions they make. It is therefore important that residents have access to an independent review process. A review process for section 26(3) decisions could be included in the mandate of an existing review board, such as the Mental Health Review Board or the Community Care and Assisted Living Appeal Board, both of which currently perform functions that are consistent with this obligation.

Section 34 of the Act gives cabinet the power to create a legally binding process for decisions made under section 26(3). If the ministry believes its approach to interpreting and implementing section 26(3) is appropriate, it should take the steps necessary to ensure that this process is set out in regulation.

Assisted Living

The Ombudsperson finds that

- F50. The Ministry of Health has not established a legally binding process to guide decisions made by assisted living operators under section 26(3) of the *Community Care and Assisted Living Act* about the decision-making capacity of assisted living residents.

The Ombudsperson recommends that

- R59. The Ministry of Health create a legally binding process with appropriate procedural safeguards for determining whether assisted living applicants and residents have the required decision-making capacity.
- R60. If the Ministry of Health retains the test in section 26(3) of the *Community Care and Assisted Living Act*, it provide more specific direction on the meaning of the phrase “unable to make decisions on their own behalf.”
- R61. The Ministry of Health ensure that assisted living applicants and residents have access to an independent process through which decisions about capacity made under section 26(3) can be reviewed.

Exceptions to the Eligibility Requirements

The *Community Care and Assisted Living Act* currently allows two exceptions to the legal requirement that assisted living residents be able to make decisions on their own behalf: involuntary patients who are on leave under section 37 of the *Mental Health Act* and assisted living residents who live with a spouse able to make decisions on their behalf.²⁶⁵

According to the Office of the Assisted Living Registrar, it has gone beyond the exception for spouses and will recognize a broader range of relationships. While recognizing other relationships, such as siblings or friends, provides seniors with more options, the ministry does not have the legal authority to broaden an exception to a legislative requirement.

²⁶⁵ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 25, s. 26(4) and (6). Section 26(4) of the Act enables people on leave under section 37 of the *Mental Health Act* to live in assisted living. The individual is exempted from making an informed decision to enter into the assisted living residence because the director of the mental health facility makes this decision for him or her. According to policy 5 of the *OALR Registrant Handbook*, because section 26(4) does not establish someone to live with the person and provide daily decision-making support, the person is not exempt from being able to make the range of decisions necessary to function safely in assisted living. There is at present only one resident in assisted living who is on leave under section 37 of the *Mental Health Act*.

Assisted Living

The Ombudsperson finds that

F51. The Ministry of Health does not have the legal authority to recognize relationships other than spousal relationships when dealing with the exceptions to the provision of the *Community Care and Assisted Living Act* that requires assisted living residents to be able to make their own decisions.

The Ombudsperson recommends that

R62. The Ministry of Health take the steps necessary to broaden the exception in section 26(6) of the *Community Care and Assisted Living Act* to include a wider range of relationships.

The Placement Process

Waiting for Placement

Once seniors are designated as eligible for placement in publicly subsidized assisted living, they can visit different residences and decide which ones best suit them. The ministry's revised *Home and Community Care Policy Manual*, which took effect April 1, 2011, states that seniors must be given the opportunity to identify a preferred residence or location. Once seniors make their choices, they will be added to the waiting lists for their preferred residences.

Before the revised manual took effect, ministry policy required seniors to be placed in assisted living residences in chronological order. However, in February 2011, the ministry informed us that they were moving away from this chronological system toward determining priority based on need, which is how placement in residential care is now determined. This is reflected in the revised policy manual, which requires health authorities to establish how they will determine priority among clients who have equal degrees of need.²⁶⁶

The following table summarizes the information we received from the health authorities about the average number of days after assessment that people waited to be placed in a subsidized assisted living.

"There was a 1.5 year wait to get into assisted living. During the time [my mother] was waiting to get into assisted living, she had home support up to four times per day plus continual visits (every few hours) from family. She also ended up in hospital two or three times. ..."

Source: Respondent, Ombudsperson's questionnaire.

²⁶⁶ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Housing and Health Services: Assisted Living Services, 5.B.2.

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Table 17 – Average Number of Days After Assessment That Seniors Spent Waiting for Placement, 2008/09 to 2010/11

Fiscal Year	FHA*	IHA	NHA ¹	VCHA ²	VIHA
2008/09	80	185	Unavailable	172	188
2009/10	78	146	Unavailable	Unavailable	208
2010/11	120	160	357	300	279

* Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

¹ The NHA was not able to provide this data for 2008/09 or 2009/10. The NHA explained that this information was recorded through the Continuing Care Information Management System (CCIMS) and stored in the Ministry of Health's data warehouse.

² The VCHA could not provide complete data for 2008/09 or 2009/10 due to the implementation of a new information system.

Between 2009/10 and 2010/11, waiting times for placement in subsidized assisted living went up in every health authority that tracked this information. The shortest waiting time in 2010/11 was in Fraser Health, where seniors waited four months on average. The longest waiting time was in Northern Health, where seniors waited on average almost one year for placement in subsidized assisted living.

We also wanted to find out how many people in the province were eligible and waiting for placement in subsidized assisted living. We asked the health authorities for their waiting list figures and were able to obtain them from the five health authorities. Based on the information we received from the health authorities, 1,628 people in British Columbia were waiting for placement in subsidized assisted living units as of March 31, 2011. This is about 37 per cent of the total number of subsidized assisted living units in the province.

The ministry places responsibility for the management of assisted living waiting lists on the health authorities and does not have any specific policies to guide them in this task. While the February 2009 minister's directive required the health authorities to report the average number of days from referral to the start of home support services, it did not require health authorities to report waiting times for placement in a subsidized assisted living unit.

Establishing a time frame for the provision of services, from the time a senior is assessed as eligible to admission would create greater accountability and provide benchmarks of service quality. Time frames would lead to increased accountability and would allow the health authorities to measure their programs against an objective and measurable standard. Time frames would help seniors and their families to better plan for their care. Finally, the monitoring, and reporting of, time frames is consistent with the ministry's stewardship role and promote openness and transparency in service delivery.

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The Ombudsperson finds that

- F52. The Ministry of Health has not established a time frame within which seniors are to receive subsidized assisted living services following an assessment.

The Ombudsperson recommends that

- R63. The Ministry of Health set a time frame within which eligible seniors are to receive subsidized assisted living services after assessment.

The Ombudsperson finds that

- F53. The Ministry of Health does not track and report the time it takes for seniors to receive assisted living services after assessment.

The Ombudsperson recommends that

- R64. The Ministry of Health require the health authorities report the average and maximum times that eligible seniors wait to receive subsidized assisted living services to the ministry quarterly.
- R65. The Ministry of Health report annually to the public on the average and maximum times that eligible seniors wait to receive subsidized assisted living services after assessment.

Declining a Subsidized Assisted Living Unit

Seniors who are offered a subsidized assisted living unit are not always able or willing to accept that placement. This may occur for a variety of reasons, including being unable to move within the time allowed. What happens in this situation varies from one health authority to another because the health authorities are allowed by the Ministry of Health to set their own policies in this area. During our investigation, we learned that some health authorities removed seniors from waiting lists when they refused a placement.

Best Practice – Vancouver Island Health Authority

Declining an assisted living placement in VIHA does not affect the applicant's position on waiting lists.

We decided to examine the health authorities' practices in this area because we were concerned that removing people from waiting lists because they refuse an offered placement may not take individual circumstances into account. It could also result in seniors having to be reassessed for services even though their need for them had already been established.

When we asked health authorities how they handle such situations, we learned that the Vancouver Island Health Authority does not remove people from assisted living waiting lists if they decline an offered placement.

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In Fraser Health, seniors can turn down an offered assisted living unit once, without it affecting their position on the waiting list. However, those who turn down a second placement will be removed from any waiting lists they are on. People who still want to be placed in assisted living must then reapply and be reassessed.

In Vancouver Coastal Health, seniors who decline the first assisted living placement offered are removed from waiting lists, but exceptions are made for those who are temporarily unable to accept a unit due to certain circumstances beyond their control, such as hospitalization.

In Interior Health and Northern Health, seniors who decline the first assisted living placement offered are removed from waiting lists and must reapply and be reassessed if they still want these services.

Moving into a Subsidized Assisted Living Unit

During our investigation, we heard from people who told us that they had not had enough time to move into a subsidized assisted living unit that was offered to them. We were concerned about this because moving takes time: seniors and their families may have to notify a landlord, cancel utility accounts, pack their belongings and arrange for movers. Most people find it very difficult or may be unable to move with only a few days' or even one week's notice.

Operators of assisted living residences have also explained to us the difficulties they face in holding subsidized units open. Health authorities only pay them for the time subsidized units are actually occupied, so having empty units can cause financial problems.²⁶⁷

We looked at whether the amount of time health authorities provide for seniors to move into assisted living is reasonable. During our investigation, we learned that the Ministry of Health does not have a policy on the length of time provided to move into assisted living residences. Instead, the ministry requires the health authorities to manage this process — and their approaches vary widely.

For example, in Vancouver Coastal Health, once a unit is offered, it must be accepted within 48 hours. The person accepting the offer then has up to two months from the date of the offer to move in. In Fraser Health, seniors are allowed the same amount of time to accept an offered unit, but have only two weeks from the date of the pre-occupancy meeting to move in. In the Interior Health Authority, seniors are expected to accept an offer within 48 hours and are encouraged to move in promptly after that, though the actual move-in date can be negotiated with the operator.

Neither VIHA nor the Northern Health Authority appear to have a clear policy, as neither could tell us how much time they allow for seniors who have accepted an offered unit to move in.

²⁶⁷ VIHA informed us that it pays contracted operators of assisted living residences a “vacant rate” during the period between when a unit becomes vacant and when a new client moves into the unit, up to a maximum of six months. VIHA stated that the “vacant rate” is lower than the rate paid when the unit is occupied.

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The Ombudsperson finds that

F54. The health authorities' practices vary widely in the length of time they give people to move into a subsidized assisted living unit after it has been offered, and on the consequences of declining an offered unit.

The Ombudsperson recommends that

R66. The Ministry of Health work with the health authorities to develop a clear and consistent provincial policy that provides reasonable time frames for moving, has the flexibility to respond to individual circumstances and sets out:

- how long a person has to accept an offered placement in an assisted living residence
- how long a person has to move into an assisted living unit once it has been offered
- any consequences of declining an offered placement

The Exit Process

Whether seniors live in a subsidized or non-subsidized unit, the ministry's policy requires them to move if they:

- are no longer able to make decisions on their own behalf
- exhibit behaviours that jeopardize their own safety and well-being or that of others
- do not comply with the terms of their residency agreement.

The ministry's *Registrant Handbook* explains that if it appears that a resident is only temporarily unable to make decisions, an operator can allow that person to continue living in the residence while monitoring the situation.²⁶⁸ For example, if health professionals have indicated that a resident's decline in capacity is slow or manageable, or that the resident's condition is treatable and likely to be short-term, the operator is not required to begin the exit process.

However, if a resident's inability to make the necessary decisions is considered permanent, operators are supposed to start the exit process. Exit plans must include the following information:

- where and how the resident will be relocated
- who is responsible for relocation arrangements
- what additional services will be provided to the resident until the move takes place to ensure the resident's health and safety are not at risk

Section 26(3) of the *Community Care and Assisted Living Act* states that an operator "must not house in an assisted living residence persons who are unable to make decisions on their own behalf." This wording indicates that once a resident is unable to make decisions, he or she should be moved quickly. Since people who are unable to make decisions on their own behalf need a higher level of care, moving out of assisted living generally requires that a residential care bed be available. Unfortunately, the demand for residential care often exceeds the number of available beds, so a waiting period is usually necessary. These conflicting pressures and demands are difficult to manage and it appears that the ministry has interpreted section 26(3)

²⁶⁸ Office of the Assisted Living Registrar, *Registrant Handbook*, October 2009, Resident Entry and Exit, 25.

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liberally so that operators can continue to house people unable to make their own decisions while alternative arrangements are made. While the ministry policy that allows operators to temporarily house and provide additional services to residents may be a reasonable response in these circumstances, the ministry is still acting outside the authority of the Act. As discussed previously, more guidance is needed from the ministry as to how section 26(3) is to be applied. (This issue is discussed later in this section under “The Role of Assisted Living Operators.”)

It is important and reasonable for operators to continue supporting residents whose needs have increased. However, as we have already discussed, allowing assisted living operators to offer more services than originally intended creates an overlap between assisted living and residential care that contradicts the clear distinction between the two that is made in the Act. If as a result of this policy, an operator ends up providing three or more prescribed services, this makes licensing necessary under the Act. The ministry does not have the authority to expand the legal definition of “assisted living” by permitting operators, even temporarily, to provide more than two prescribed services. (This issue is discussed earlier in this section under “The Assisted Living Registrar’s Policy on Providing Prescribed Services at the Support Level.”)

The ministry’s policy says that operators should assist residents who are no longer able to make their own decisions to move to more appropriate care settings as quickly as possible. While ideally this happens in a timely way, the assessment may not be immediate and then moves may be delayed because of a health authority’s inability to provide access to a subsidized residential care bed.

The information we received from health authorities on waiting times for transfers from assisted living to residential care was incomplete. The data that they could provide is included in the table below.

Table 18 — Assisted Living Residents Awaiting Placement in Residential Care on March 31, 2011

Health authority*	Number of residents	Average waiting time (in days)
FHA	13	60
IHA ¹	30	132
NHA ²	Not available	Not available
VCHA	11	128
VIHA	48	148

* Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

¹ The IHA data is incomplete due to an information system upgrade that made this information for Kootenay Boundary clients unavailable.

² The NHA was unable to provide this information.

As of March 31, 2011, more than 100 people in assisted living residences had been assessed as in need of residential care and were waiting for placement. Average waiting times for placement varied from two months to five months. This means that assisted living operators are caring for people who after have been identified as requiring a higher level of care still remain in assisted living for some time.

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The Ombudsperson finds that

- F55. The Ministry of Health policy that requires operators to provide additional support to residents during the exit process results in operators providing more than the maximum two prescribed services for an undefined time frame.

The Ombudsperson recommends that

- R67. The Ministry of Health take the steps necessary to provide facility operators with the legal authority to offer additional support to assisted living residents during the exit process.
- R68. The Ministry of Health establish reasonable time frames for completing the exit process for assisted living residents.

Quality of Care

During our investigation, seniors and their families told us that the quality of assisted living services was their biggest concern. The following sections of this report examine how the quality of care provided in assisted living residences is measured, evaluated and monitored.

In addition to housing, assisted living operators are required to offer hospitality services and prescribed services to residents. Hospitality services are hotel-like in nature and defined in the *Community Care and Assisted Living Act* as including meals, housekeeping and laundry, as well as the provision of social and recreational programs and emergency response systems.²⁶⁹ As discussed earlier, residences also offer one or two prescribed services. Currently, all operators provide assistance with bathing, dressing, grooming, moving around, eating and medications. Whenever someone moves into an assisted living residence, operators are supposed to develop a care plan that outlines the services they will provide to meet that person's particular needs. The actual care services that operators provide to assisted living residents may vary somewhat from one residence to another depending on whether the residence has opted to provide prescribed services at the support level.

Legal Requirements

While assisted living operators may be guided by policies on quality of care, they can only be required to comply with the legally binding standards set out in the Act and regulations. Accordingly, operators must ensure that they comply with the *Community Care and Assisted Living Act*, the *Community Care and Assisted Living Regulation* and the *Assisted Living Regulation*. The provisions of the Act that relate specifically to the quality of the care in assisted living are set out in section 26. They state that assisted living operators:

Regulatory Standards

The only regulatory standards that apply to assisted living operators are on storing and administering medications.

²⁶⁹ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, s. 1.

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- must not operate an assisted living residence that is not registered
- must not house residents who are unable to make decisions on their own behalf
- must ensure that their assisted living residence is operated in a manner that does not jeopardize the health or safety of its residents²⁷⁰

Although section 34 of the *Community Care and Assisted Living Act* allows the cabinet to make regulations about assisted living, which could include care standards, the only regulatory provisions the cabinet has made are on storing and administering medication. These are contained in the *Assisted Living Regulation* and are the only regulatory standards that apply to assisted living operators.²⁷¹

The remaining guidelines that apply to assisted living operators are found in policy, not legislation or regulation, and concern staffing, food services and housekeeping.

When the assisted living provisions in the *Community Care and Assisted Living Act* came into force on May 30, 2004, the provincial government planned to include health and safety standards in regulation. This never happened. Instead, in 2007, the ministry developed its own health and safety policy to guide operators and assist them to comply with the Act.

The Ministry of Health's Policy on Health and Safety

In August 2007, the Ministry of Health published policy 4, "Health and Safety Standards," in its *Registrant Handbook*.²⁷² The policy sets out how operators can meet the requirement of the Act that ensures their residence is operated in a manner that "does not jeopardize residents' health and safety." The ministry describes its policy as "high level and outcome-based."²⁷³

The ministry health and safety policy states that:

1. Registrants must provide a safe, secure and sanitary environment for residents.
2. Registrants must ensure hospitality services do not place the health and safety of residents at risk.
3. Registrants must ensure sufficient staff is available to meet the service needs of residents and that staff has the knowledge and ability to perform their assigned tasks.
4. Registrants must ensure residents are safely accommodated in their assisted living residence, given its design and available hospitality and prescribed services.
5. Registrants must develop and maintain personal services plans that reflect each resident's needs, risks, service requests and service plan.
6. Registrants must ensure personal assistance services are provided in a manner that does not place the health or safety of residents at risk.²⁷⁴

²⁷⁰ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, s. 26.

²⁷¹ *Assisted Living Regulation*, B.C. Reg. 218/2004, ss. 5 and 6.

²⁷² Office of the Assisted Living Registrar, *Registrant Handbook*, October 2009, Health and Safety Standards, 4, 1.

²⁷³ Office of the Assisted Living Registrar, *Registrant Handbook*, October 2009, Health and Safety Standards, 4.1 and 4.2.

²⁷⁴ Office of the Assisted Living Registrar, *Registrant Handbook*, October 2009, Health and Safety Standards, 4.2.

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While the outcomes are quite general, each also includes examples of what can be done to achieve it. For instance the outcome for housekeeping services, considered a hospitality service, is that operators “provide housekeeping in resident units that maintains a safe, clean and sanitary environment.” Examples include “spot checks” to verify the absence of safety hazards, such as frayed electrical cords, and “survey results” indicating that residents are satisfied.

While section 26(4) of the Act requires operators to ensure that their assisted living residence is operated in a manner that does not jeopardize the health and safety of its residents, it provides no further detail on how this should be accomplished. The ministry developed its health and safety policy to guide operators on this point, but its outcomes are general and subject to interpretation. While the examples do provide some further clarity, they serve only as guides and, according to the policy, are “not intended to limit or dictate how registrants will achieve the desired outcomes.”²⁷⁵

The ministry identifies meeting its health and safety policy as an obligation of operators. The registrar has also stated that she expects operators to meet both the standards and the outcomes. However, the Office of the Assisted Living Registrar (OALR) health and safety policy does not have the binding authority of a regulation.

This does not mean that government policy is never considered to be law. In *Greater Vancouver Transportation Authority v. Canadian Federation of Students — British Columbia Component*, the Supreme Court of Canada held that when the Legislature empowers a government entity to make rules, absent evidence to the contrary, the Legislature intends those rules to be binding.²⁷⁶

However, the *Community Care and Assisted Living Act (CCALA)* does not empower the ministry to make rules. That power does exist, but it is in the hands of cabinet and has rarely been used. Section 34(3)(e) of the *CCALA* states that the Lieutenant-Governor-in-Council may make regulations prescribing the health and safety standards that must be met in the delivery of services at an assisted living residence.

By comparison, under section 4(1)(e) of the Act, the director of licensing for residential care has authority to “specify policies and standards of practice for all community care facilities.”²⁷⁷ It is important to note that the phrase “policies and standards” refers, in this context, to rules made by someone who has been given the explicit authority to do so under the law, and can thus be considered “soft law.” This, however, does not apply to all “policies and standards.” The assisted living policies of the ministry would not be considered soft law because they were not created under specific legislative authority.

The Ministry of Finance’s Internal Audit and Advisory Services (IAAS) issued a report about the OALR in June 2007. In this report, IAAS noted that converting the office’s health and safety policy into regulation would increase the Ministry of Health’s ability to enforce the policy because it “would provide the registrar with the force of law to help ensure that operators comply. Currently, only the standards related to administering and storing medication are part of the regulations.” More than four years later, the ministry is still considering the recommendations from IAAS but has not yet acted on them.

²⁷⁵ Office of the Assisted Living Registrar, *Registrant Handbook*, October 2009, Health and Safety Standards, 4.2.

²⁷⁶ *Greater Vancouver Transportation Authority v. Canadian Federation of Students — British Columbia Component*, 2009 S.C.C. 31, [2009] 2 S.C.R. 295 (Q.L.).

²⁷⁷ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, s. 4(1)(e).

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Area of Concern: Staffing

A provision in the ministry's health and safety policy is that "registrants must ensure sufficient staff is available to meet the service needs of residents and that staff has the knowledge and ability to perform their assigned tasks."

The policy also includes the following desired outcomes:

- ensure site management is effective and appropriate for the resident population
- ensure staffing levels are sufficient to meet the hospitality service needs of residents and deliver the personal assistance services offered
- ensure that staff has qualifications consistent with their job responsibilities
- provide staff orientation and ongoing training to develop and maintain staff knowledge and skills.
- ensure appropriate delegation of professional tasks to nonprofessional staff, consistent with the *Personal Assistance Guidelines*²⁷⁸

However, there is nothing in the Act, Regulation or policy about specific provisions for the staffing mix, staff-to-resident ratio, employee orientation, training and education, or background checks.

In contrast, the BC Seniors Living Association has developed more detailed and specific provisions for staffing under its Seal of Approval Program. In order to receive the Seal of Approval, an assisted living residence must be in compliance with all provisions of the program at the time it is first surveyed and also at each subsequent survey, which is done every two years. The Seal of Approval Program includes the following provisions related to staffing:

- There is a confidential personal record for each staff member and pre-employment references are obtained and documented, as well as a criminal record check completed, prior to commencement of employment.
- There is a written orientation program for staff which includes customer service, handling complaints, dealing with medical emergencies, and WorkSafeBC, and occupational health and safety training to initiate new staff to the residence, all aspects of their job, and emergency procedures.
- There is a staff development program and continuing education program for staff that is responsive to the changing needs of the residents. This includes training in areas such as Fire Safety, Prevention of Elder Abuse, Dealing with Aggressive Residents, Infection Control, and the Assisted Living Registrar's complaint process.
- Staff providing personal services possess appropriate education and training.²⁷⁹

The Seal of Approval is a useful example of staffing provisions that are more specific and prescriptive than those established by the ministry. The outcome-based policies used by the ministry make it difficult to determine whether operators are in compliance or to assess the validity of a complaint about staffing because there are no specifics against which performance can be evaluated.

²⁷⁸ Office of the Assisted Living Registrar, *Registrant Handbook*, October 2009, Health and Safety Standards, 4.3, #3.

²⁷⁹ BC Seniors Living Association, *Seal of Approval: Introductory Package*, Standards 3.10, 4.01, 4.02, 5.09 <<http://www.bcsla.ca/home.html>>.

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Other Areas of Concern

In addition to staffing, there are other areas where clear legally binding standards for assisted living residences would be of assistance. These areas are ones that are essential to ensuring that assisted living residents receive a quality of care that promotes their health, safety, dignity and overall well-being. They include:

- residents' rights
- food safety and nutrition
- emergencies
- record management
- assistance with daily activities

We have not included the use of restraints in this list because we have not found any information that they are being used in assisted living facilities. However, if in certain circumstances the use of restraints in assisted living is ever considered, legally binding standards should be created.

The Ombudsperson finds that

F56. The Ministry of Health has not established legally binding standards for key areas in assisted living such as staffing, residents' rights, food safety and nutrition, emergencies, record management, and assistance with activities of daily living.

The Ombudsperson recommends that

R69. The Ministry of Health, after consulting with stakeholders, establish legally binding minimum requirements for assisted living residences in key areas, including:

- staffing
- residents' rights
- food safety and nutrition
- emergencies
- record management
- assistance with activities of daily living

R70. The Ministry of Health provide clear and accessible information to residents on the standards assisted living operators are required to meet.

Complaints

Concerns of assisted living residents and their families include eligibility and placement decisions, waiting times, food, personal care, activities, rent increases and evictions. There is no single agency that will accept and can deal with all complaints about assisted living, although there are several agencies that can deal with complaints about certain issues.

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Residents and families are encouraged to first raise their concerns directly with the residence operator or service provider. However, if the problem can't be resolved at that level, there are a number of possible options, depending on what the complaint is about and whether the resident is in a subsidized or a non-subsidized unit. Determining which agency has the power to resolve a particular issue can be confusing for assisted living residents and their families.

Residents of publicly subsidized assisted living residences can complain to the Office of the Assisted Living Registrar (OALR) about health and safety issues. Complaints about quality of care can be taken to the operator or to the regional patient care quality office (PCQO), and the regional patient care quality review board (PCQRB). Complaints about placement and transfer issues can be brought to the resident's case manager at the health authority.

Residents of non-subsidized assisted living residences have fewer avenues for complaint. Health and safety complaints can still be taken to the OALR, but all other issues can be dealt with only by the facility operator or contracted service provider.

Table 19 – Types of Complaints and Who Receives Them

Complainant	Informal complaints	Complaints about health and safety	Complaints about quality of care	Complaints about placement and transfer issues
Resident in a subsidized unit	Facility operator or contracted service provider	Office of the Assisted Living Registrar	Regional patient care quality office and patient care quality review board	Health authority case manager
Resident in a non-subsidized unit	Facility operator or contracted service provider	Office of the Assisted Living Registrar	Facility operator or contracted service provider	Not applicable

In February 2009, the former Minister of Health Services issued a directive requiring the health authorities to make information on how to complain about home and community care services, including assisted living, available to the public. This information was supposed to include details on review processes and direct contact information for the designated staff members responsible for receiving complaints in each area. According to the minister's directive, revisions to the health authority websites were supposed to be completed by October 31, 2010.

In June 2011, we reviewed the health authorities' websites to determine whether they had complied with the minister's directive. We found that although each health authority provided most of the information required by the directive, the Vancouver Island Health Authority was the only authority in full compliance at that time. The Vancouver Coastal Health Authority's website provided links to the websites of the PCQRB and the OALR, but no direct contact information.

In December 2011, we revisited the health authorities' websites. Once again, we found that each health authority had most of the information required by the directive; however, only VIHA and Vancouver Coastal websites were in full compliance, providing both descriptions of the complaint processes and direct contact

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information for the PCQO, PCQRB and OALR. The other authorities had gaps in their information about these core complaints services. For example, the Fraser Health website did not provide direct contact information for the OALR, while the Interior Health website lacked a description of the complaints processes and direct contact information for the PCQRB and OALR. The Northern Health website did not provide a description of the complaints process or direct contact information for the OALR.

The Ombudsperson finds that

F57. The Fraser Health Authority, Interior Health Authority and Northern Health Authority have not yet fully complied with the minister's directive.

The Ombudsperson recommends that

R71. The Fraser Health Authority, Interior Health Authority and Northern Health Authority fully comply with the minister's directive by:

- in the case of the Fraser Health Authority, providing direct contact information for the Office of the Assisted Living Registrar (OALR),
- in the case of the Interior Health Authority, including a description of the complaints processes and direct contact information for the patient care quality review board and OALR, and
- in the case of the Northern Health Authority, providing a description of the complaint process and direct contact information for the OALR.

Complaints to Assisted Living Operators

Facility operators are generally the first point of contact for complaints about assisted living. The *Registrant Handbook* indicates that each operator should have a written complaints process, should make residents and others involved in their care aware of it, and should include contact information for the Office of the Assisted Living Registrar (OALR).²⁸⁰ As discussed earlier, this is not a legal requirement. The handbook does not give any guidance regarding what the complaints process should involve or look like.

OALR staff told us that operators must provide the office with copies of their written complaints process prior to registration. However, during visits to 13 different assisted living residences in the course of this investigation, we heard from assisted living residents who said they were unsure of who was responsible for responding to care complaints. People who contacted our office also told us they were unsure of where to go with their complaints. In some cases, confusion over whom to complain to may be due to the way that subsidized assisted living services are delivered. In British Columbia, there are two different models for doing so: the classic model and the VIHA/Northern Health model.

In the classic model, which is used by the Fraser, Interior and Vancouver Coastal health authorities, the operator is responsible for delivering housing, hospitality and prescribed services. In this model, it is clear that the operator is responsible for responding to complaints about any of these services.

²⁸⁰ Office of the Assisted Living Registrar, *Registrant Handbook*, August 2007, Complaint Resolution, 9.1.

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However, under the VIHA/Northern Health model, the operator is responsible for delivering housing and hospitality services, while the health authority is responsible for delivering support with the activities of daily living or personal care. In this model, it is less clear who is responsible for responding to complaints about personal care.

In addition, other contractors and subcontractors may be involved in providing services in any assisted living residence, regardless of who owns or operates it. When this is the case, it can be difficult for residents or their families to know where to take their concerns. For example, if a resident has a complaint about food that is provided by a contractor, it is not clear whether that complaint should be taken directly to the contractor or to the facility operator instead. As well, if a resident has a complaint about care that is provided by a contracted care provider, it is not clear whether that complaint should go to the contractor or the operator.

Given that assisted living services may be delivered by a variety of agencies, it is especially important for residents and their families to have clear information about who is providing the various services they are receiving, and where they can bring concerns about those services.

The Ombudsperson finds that

F58. Assisted living operators are not required by law to have a process for responding to complaints.

The Ombudsperson recommends that

R72. The Ministry of Health take the necessary steps to establish a legal requirement for assisted living operators to have a process for responding to complaints, and to establish specific standards for that process.

The Ombudsperson finds that

F59. The health authorities do not ensure that operators provide clear and comprehensive information to assisted living residents on how to complain about the care and services they receive.

The Ombudsperson recommends that

R73. The health authorities ensure that by September 30, 2012, all assisted living operators are providing residents with clear and comprehensive information on how to complain about the care and services they receive, including where to take complaints about services provided by contractors.

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Complaints to Case Managers

Case managers are responsible for determining the eligibility of applicants and the fees they will pay for subsidized assisted living services.²⁸¹ They monitor and assess residents' ongoing eligibility for assisted living. They also find other appropriate housing for residents no longer eligible for assisted living and ensure that these residents are supported in the meantime.

While all the health authorities said that they inform assisted living applicants and residents that they can bring their complaints to case managers, none have an established process for responding to complaints at this level. Since case managers are employed by health authorities, complaining to them is only an option for subsidized residents. Those who pay for assisted living privately do not have access to this avenue of complaint. Residents receiving a subsidy can complain to a case manager about their care and about access to services and fees. Complaints to case managers, however, are handled informally. There are no time limits for responding to such complaints and health authorities do not typically track them.

Most complaints at this level are raised by people in the course of an ongoing relationship with their case manager. Given that there are already formal complaints processes in place, there is value in maintaining this as a more informal system for handling complaints. However, it is still important for the health authorities to track complaints made to case managers in order to identify and address recurring issues.

The Ombudsperson finds that

F60. The health authorities do not track complaints about assisted living that are made to case managers.

The Ombudsperson recommends that

R74. The health authorities develop and implement a process for tracking complaints made to case managers about assisted living.

Complaints to the Office of the Assisted Living Registrar

Unlike oversight in residential care settings, oversight of assisted living is mainly reactive and carried out in response to complaints, rather than on an ongoing and routine basis. Anyone can complain directly to the Office of the Assisted Living Registrar (OALR) by telephone, e-mail, fax or in person. While the OALR encourages people with concerns to take them to their operator first, the office will consider matters that have not been brought to the operator, if it believes that there is an imminent risk to health and safety. According to the ministry, the OALR responds to complaints about:

- violations of the health and safety policies contained in the *Registrant Handbook*
- allegations that an operator is housing residents who are unable to make their own decisions
- the operation of unregistered assisted living residences²⁸²

²⁸¹ Note that while the term “case manager” is used here, the ministry’s revised policy manual refers to assessments being done by a “health professional”. Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Assessment, 2.D.

²⁸² Office of the Assisted Living Registrar, *Registrant Handbook*, August 2007, Complaint Resolution, 9.2.

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The OALR does not respond to complaints about tenancy issues, such as evictions or rent increases, or to service quality issues, such as food quality. OALR staff will only consider a service quality issue if they are satisfied that it constitutes a threat to residents' health and safety. For example, if the OALR receives a food quality complaint that its staff decide is not a health and safety issue, they will refer the complainant to the facility operator. The OALR also does not respond to complaints about staff or operational issues unless the OALR decides that such complaints relate directly to the health and safety of residents.

Table 20 – Complaints to the Office of the Assisted Living Registrar, 2004/05 to 2010/11

Fiscal year	Number of assisted living residences	Number of assisted living units	Complaints received	Non-jurisdictional complaints	Jurisdictional complaints	Complaints that resulted in inspection
2004/05	54	1,786	58	44	14	1
2005/06	96	3,367	42	27	15	4
2006/07	117	4,231	67	45	22	5
2007/08	150	5,235	89	32	57	7
2008/09	184	6,187	68	22	46	8
2009/10	196	6,685	84	12	72	6
2010/11	194	6,832	75	8	67	4
Total complaints			483	190	293	35

As shown in this table, the complaints the OALR received between 2004/05 and 2010/11 were a mix of jurisdictional and non-jurisdictional complaints. These complaints were about the management of unregistered assisted living residences, nutrition, tenancy issues, staffing, abuse and neglect of residents, and the administration of medication. Almost half the complaints received by the OALR in this period were outside its jurisdiction. This high proportion of non-jurisdictional complaints demonstrates an ongoing confusion about where to take complaints, and emphasizes the need for a streamlined complaints process with a single point of contact for complainants.

How the Office of the Assisted Living Registrar Handles Complaints

When the OALR receives a complaint that it determines is not within its jurisdiction, the office refers the complainant elsewhere if it is aware of another agency that may have jurisdiction. If the OALR decides a complaint is within its jurisdiction, the registrar or a member of her staff may take one or more of the following steps:

- gather more information
- educate the operator or the person complaining about the requirements under the applicable regulations and policies (this may be dealt with through a simple telephone call)
- conduct a review to determine whether the operator is complying with the OALR's health and safety policies
- inspect the residence

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The approach the OALR takes to complaint resolution is educational and remedial. When it receives a complaint that it determines to be within its jurisdiction to investigate, its usual response is to confirm whether the operator is following its health and safety policies. If the operator is not doing so, the OALR will tell the operator how to comply with the policy. Staff only report the outcome of a complaint to the person who complained when they have been specifically asked to do so. There is no right of review or appeal for decisions about complaints made by the OALR to another body in the Ministry of Health or an administrative tribunal. People who are not satisfied with the OALR's handling of their complaint can complain to the Office of the Ombudsperson, though not everyone may be made aware of this.

Ombudsperson's Review of OALR Complaint Files

As part of this investigation, Ombudsperson staff reviewed a random selection of 25 complaints the OALR received in 2007, 2008 and 2009. Seven of these were from 2007, four were from 2008 and fourteen from 2009.

Of the 25 complaints we reviewed, only one was made by a resident. Twelve were made by friends and family members, four by former staff, six by health authority staff and the remaining three by other individuals. Fourteen of the complaints we reviewed related to seniors in non-subsidized units and six related to seniors in subsidized units. In the remaining five files, it was not clear how the unit was funded.

We looked at how the complaints were investigated and resolved. In each case, the OALR contacted the facility operator by telephone or e-mail to discuss the complaint. In 17 cases, OALR staff requested that operators provide copies of their policies and procedures on resident reassessment and exit plans. In the other eight cases, OALR staff considered verbal information from operators sufficient.

There was nothing in these files to indicate that OALR staff either interviewed residents or reviewed their case files when responding to complaints involving resident decision-making capacity. Rather, OALR staff asked operators about residents' capacity to make decisions and seemed to accept the information they provided.

Based on our review, the OALR complaint process generally focuses on operators' policies and procedures and their compliance with the OALR health and safety policies. We noticed that OALR staff frequently closed files after determining that operators had policies and procedures and the knowledge required to meet the relevant health and safety requirements. Four of the 25 complaints we reviewed resulted in on-site inspections.

In 13 of the 25 files we reviewed, OALR staff determined that the office's health and safety policies had been followed. In the other 12, the OALR took steps to achieve a resolution. However, we saw no evidence of OALR staff following up with operators to ensure that the changes they agreed to make were in fact implemented, making it difficult to determine whether the steps taken by the OALR were successful.

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The OALR does not have time limits for responding to complaints. In the absence of such limits, the volume of complaints and the number of staff determine response times. For the 25 files we reviewed, the average length of time a file was open was 109 calendar days (three and a half months). The shortest number of days required to close a file was four and the longest was 253. In 2007, the average number of days it took to close a file was 62. In 2009, it was 143.

In the course of our review, we observed that while OALR staff always contacted operators at the conclusion of an investigation, they did not consistently do the same for the people who made the complaints. In five cases, there was no evidence that the complainant was contacted at all. We found no evidence that staff informed complainants about other available avenues of complaint.

Analysis

The OALR is the part of the Ministry of Health responsible for “protecting the health and safety of assisted living residents.” In order to do so, it needs to respond to complaints consistently, thoroughly and within defined time limits. This is especially important given that its oversight is mainly reactive, rather than proactive, and thus depends in large part on its response to complaints.

Based on our observations, OALR staff respond to complaints within their jurisdiction. However, the OALR needs to take a more rigorous approach to complaint investigation, especially when it comes to determining whether a complaint requires further action beyond a review of the operator’s policies and procedures.

The effectiveness of a complaint-driven oversight process depends on the rigorous and timely investigation of complaints and on following up to ensure that operators take necessary corrective actions. The effectiveness of the OALR’s complaints process would be improved by monitoring operators to ensure that they implement steps it has directed them to take. The transparency of the OALR’s complaint process would also be improved if the office routinely informed complainants of the results of investigations, and of other available avenues of complaint.

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The Ombudsperson finds that

- F61. The complaints process used by the Office of the Assisted Living Registrar does not:
- establish time limits for responding to complaints
 - include an established process for investigating complaints
 - require its staff to provide the person who complained with written information on the outcome of its investigation and any further actions they can take
 - require its staff to monitor whether operators implement the action it has recommended to resolve complaints

The Ombudsperson recommends that

- R75. The Ministry of Health revise the complaints process used by the Office of the Assisted Living Registrar to include:
- time limits for responding to complaints
 - an established process for investigating complaints
 - a requirement that complainants be informed in writing of the outcome of their complaint and any further actions they can take
- R76. The Ministry of Health take the necessary steps to establish a right of review or appeal from decisions or complaints made to the Office of the Assisted Living Registrar.
- R77. The Ministry of Health develop a process for monitoring whether operators implement the actions it recommends through the Office of the Assisted Living Registrar to resolve complaints, and taking further action if they do not.

Complaints to the Patient Care Quality Offices and Review Boards

As of October 2008, each health authority has its own patient care quality office (PCQO) that receives and investigates complaints about health care provided in its region. A “care quality complaint” is defined as a complaint respecting the quality or delivery — or failure to deliver — health care or a related service, made by or on behalf of the person to whom the health care or service was delivered or not delivered.²⁸³

Each health authority also has its own patient care quality review board (PCQRB). While the PCQOs are part of their respective health authorities, the PCQRBs are part of the Ministry of Health and are accountable directly to its minister. (The roles of PCQOs and PCQRBs are discussed in more detail in the Home and Community Care section of this report.)

Complaining to a patient care quality office is an option only for those who receive assisted living services funded by their health authority — meaning that they live in a unit that is subsidized. Those who are not satisfied with how a PCQO handles their complaint can ask for a review by their regional PCQRB. After

²⁸³ *Patient Care Quality Review Board Act*, S.B.C. 2008, c. 35, s. 1.

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reviewing the complaint, the review board may make recommendations to the health authority or the minister about improvements to care quality or the complaints process. This can be an effective mechanism for resolving systemic problems as they arise.

Patient care quality offices cannot respond to complaints from assisted living residents who do not live in a subsidized assisted living unit (2,452 out of 6,832 units) — more than one-third of all assisted living residents. If a PCQO receives a complaint from one of these residents, it can and presumably should refer the person to the Office of the Assisted Living Registrar. As of the end of 2010, the OALR has never received a complaint referred to it from a PCQO.

Overlapping Jurisdictions — Patient Care Quality Offices and the Assisted Living Registrar

The *Patient Care Quality Review Board Act* requires patient care quality offices (PCQOs) to process all complaints that they receive about care quality unless they are “external.” Section 4 of the Act defines an external complaint as a care quality complaint that is:

- about another health authority or should be processed by another entity
- directed by the Minister of Health to be referred to another entity or included in the definition of “external complaint” by regulation of the Minister of Health

The *External Complaint Regulation* issued by the Minister of Health in October 2008 lists the complaints that are to be considered external and therefore must be referred elsewhere. Complaints about health care or services funded or provided by the health authorities, including health and safety complaints about subsidized assisted living, are not considered to be external complaints. The result is that health and safety complaints about subsidized assisted living can be dealt with by either the Office of the Assisted Living Registrar (OALR) or a PCQO, or both.

We found that the health authorities were inconsistent when referring health and safety complaints about assisted living to either the OALR or to the PCQOs. For instance, the Fraser Health Authority indicated that health and safety complaints should be directed to the OALR, but that its PCQO would investigate complaints that it was aware of and share its findings with the OALR. The Interior Health Authority stated that any health and safety complaints it receives about assisted living should be referred to the OALR. The Northern Health Authority indicated that the OALR is the appropriate avenue for health and safety complaints, but that its PCQO remains open as a point of contact. The Vancouver Coastal Health Authority indicated that it directs its clients to contact the PCQO or the OALR. VIHA indicated that it refers assisted living clients to the PCQO for complaints related to care, and to the OALR for complaints about hospitality services.

Although there appears to be some confusion in this area, people can choose whether to contact the OALR or their regional PCQO with a health and safety complaint about subsidized assisted living. Furthermore, the patient care quality offices are not required to refer health and safety complaints about assisted living to the OALR, nor are they required to advise the OALR of the outcome of such complaints.

While individuals have the right to choose which body they complain to about assisted living, there is reason for concern about the overlapping jurisdiction of the OALR and the PCQOs. When creating the OALR, the provincial government indicated it intended it to be the body that responds to health and safety complaints about assisted living. Thus, it specifically provided the OALR with the legislative power to do so. It also

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provided the OALR with some investigative and enforcement powers in order to carry out this responsibility. However, by creating the PCQOs and the review boards in 2008, the government introduced another process for responding to the same types of complaints.

The overlapping jurisdiction of the OALR and the PCQOs means that the OALR can no longer accurately track all the health and safety complaints about assisted living, which makes it difficult to effectively identify and respond to trends. Given that complaints are key to carrying out its mandate, this makes the OALR less effective. Also, while the powers of the OALR are inadequate in some respects (we discuss the need to expand these powers later in this section), the PCQOs have even fewer and weaker powers to investigate complaints and enforce consequences than the OALR does.

For instance, if the registrar believes that the health and safety of residents is at risk in an assisted living residence, OALR staff may enter and inspect the premises and make copies of any records. If the registrar finds that the health and safety of residents is at risk, the registrar may suspend, cancel or attach conditions to a residence's registration. PCQOs do not possess these investigative and remedial powers. They are confined to resolving complaints based on the information that a health authority (or its contractor) or a complainant provides. The PCQOs also do not have the power to enforce any remedial actions required to resolve a complaint.

Limitations of the Patient Care Quality Offices

The patient care quality offices (PCQOs) and review boards are limited to dealing with complaints about services that are either provided by a health authority or its contractor(s), or funded in whole or in part by a health authority. They cannot accept complaints from residents who pay for their assisted living services entirely privately, even though such residents make up approximately one-third of all assisted living residents.

The ministry's draft orientation manual for new members of the patient care quality review boards (PCQRBs) says that complaints about assisted living services that are not provided by a health authority will not be considered by the PCQOs and PCQRBs. However, subsidized assisted living services may not be provided by a health authority, but instead be funded in whole or in part by a health authority and provided by a contractor. Complaints about these assisted living services are within the current mandate of the PCQOs and PCQRBs. This error should be corrected before the orientation manual is finalized.

Despite the fact that all assisted living residences are required to be registered with the Office of the Assisted Living Registrar (OALR) and are expected to follow ministry assisted living policies, the provincial government has excluded non-subsidized assisted living services from the jurisdiction of the PCQOs and review boards. This is different from the approach the provincial government has taken to residential care, where the PCQOs and review boards are able to consider complaints about services in all residential care facilities, including those that are not subsidized.

Excluding non-subsidized assisted living services from the jurisdiction of the PCQOs and review boards creates confusion for seniors, their families and the health authorities. Residence staff do not always know whether an assisted living unit is subsidized or not. As a result, they may be unable to properly advise residents or their families on how to direct their concerns.

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Conclusion

Seniors who live in assisted living facilities rely upon the services they receive. Given the importance of these services to their health and safety, well-being and peace of mind, seniors and their families must be able to raise any concerns they may have through an easily accessible, consistent, timely and effective complaints process.

We reviewed how complaints about assisted living are dealt with, and found that the complaints processes in place are not adequately clear, consistent or thorough enough to respond effectively to the needs of seniors in assisted living. Currently, several individuals and agencies are responsible for responding to complaints about assisted living. Which agencies people can complain to and what they can complain about depends upon a variety of factors, including whether they are paying the full cost of services privately or receiving a subsidy, who delivers the service, and whether the complaint is considered to be an issue of health and safety or personal care. This leads to confusion, gaps in the complaints system and overlapping jurisdiction in some areas. It also means no single agency is able to monitor all assisted living complaints to ensure that they are handled appropriately and to identify any systemic issues that may arise. This type of monitoring is essential to identify problems before injuries or deaths occur.

Given that multiple avenues are used currently for raising concerns about assisted living, it is important that clear and comprehensive information be readily available to seniors and their families so they know how to make complaints about various issues.

It would be far more effective and fair to have a single, consistent and clearly communicated complaints process available to all assisted living residents, regardless of how they pay for their services. This process should, however, also include a mechanism that allows for communication with the home and community care section of the health authority who may have an interest in such decisions.

The Ombudsperson finds that

F62. It is unfair that all assisted living residents do not have access to the same complaints processes.

The Ombudsperson recommends that

R78. The Ministry of Health take the steps necessary to expand the powers of the Office of the Assisted Living Registrar so that it has the authority to respond to complaints about all aspects of care in assisted living from all residents.

R79. The Ministry of Health review the structure of the Office of the Assisted Living Registrar with the goal of ensuring that it has the necessary support to fulfill this expanded role.

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The Ombudsperson finds that

- F63. The overlapping jurisdiction of the Office of the Assisted Living Registrar and the patient care quality offices and the different approaches the health authorities take to resolve this overlapping authority leads to inconsistencies in how similar complaints are dealt with and is confusing for those who want to complain about assisted living.

The Ombudsperson recommends that

- R80. The Ministry of Health take the necessary steps to ensure that the patient care quality offices refer all complaints about assisted living to the Office of the Assisted Living Registrar.
- R81. The Ministry of Health establish a mechanism that allows the Office of the Assisted Living Registrar to share the results of its complaints with the home and community care sections of the health authorities on a timely basis.

Complaints about Tenancy Issues

All assisted living residents rent the units they live in and therefore would generally be thought of as tenants of the operators of their residences. In the course of our investigation, we heard from assisted living residents who were concerned about rent increases and being evicted from assisted living residences, both of which are common concerns for tenants.

The *Residential Tenancy Act* outlines the rights and responsibilities of tenants and landlords. It also provides a process for resolving tenancy disputes. However, assisted living residents are not currently covered by this Act or other comparable legislation. The Office of the Assisted Living Registrar (OALR) does not have the jurisdiction to consider complaints about tenancy issues from assisted living residents. This gap in protection leaves assisted living residents, who are generally more vulnerable than other tenants, with fewer options for recourse when issues arise. Marta's situation is one example of the kinds of problems caused by this gap. (The name below has been changed to protect confidentiality.)

Marta's Story

Marta's mother was evicted from a publicly funded non-profit assisted living residence. Staff suspected that she was smoking in her room even though residents were only allowed to smoke in an area designated for smokers. While Marta's mother denied smoking in her room and there was no physical proof of this, staff were convinced this was going on. Given the risks they saw from smoking in the suite, they decided to evict her.

After meeting with Marta and her mother three times in six months about this problem, the manager of the residence told them that despite the lack of physical proof, the risks of Marta's mother smoking in her suite were such that he was going to evict her.

At first, the manager told Marta that her mother would have to leave her suite within two days. Marta was able to convince the manager to give her two weeks to make new arrangements for her mother. If assisted living had been covered by the Residential Tenancy Act, she would have been entitled to one month's notice and could have challenged the eviction by going to the Residential Tenancy Branch.

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Although the ministry's website clearly states that the OALR does not deal with tenancy complaints, the OALR continues to receive them.²⁸⁴ Between 2004/05 and 2009/10, the OALR received a total of 41 complaints about tenancy issues, including complaints about rent increases, ending tenancy agreements, changes to (or termination of) services and security deposits. In all cases, the OALR either chose not to pursue these complaints or referred them to client relations officers at the Residential Tenancy Branch (RTB), even though that organization also has no formal or legislated process for dealing with these types of complaints.

The RTB's main role is to inform tenants and landlords about their rights and obligations under the *Residential Tenancy Act* and to resolve disputes arising from those.²⁸⁵ While dealing with assisted living residents is outside its mandate, when the RTB receives such a complaint, its staff work with the person making the complaint to clarify the nature of the dispute. With that person's permission, the RTB may contact the other party to provide information and assist both parties to resolve the dispute. However, this is an informal process and as such, lacks legal requirements or protection. It does not follow any established procedures and is not publicized. The following is an example of the type of complaint that the OALR has referred to the RTB. (The name below has been changed to protect confidentiality.)

Sarah's Story

Sarah had lived in an assisted living residence for more than two years and had paid a \$300 damage deposit when she moved in.

In March 2005, the operator of her residence sent a letter to Sarah and the other residents stating that the required damage deposit had increased to \$1,000 and that all residents would now have to make up the difference between whatever they had paid originally and this new amount.

Although the OALR website says the office doesn't deal with complaints about tenancy issues, Sarah and the other residents contacted the OALR. Since this type of complaint is outside the OALR's jurisdiction, staff there referred Sarah to a client relations officer at the RTB. The officer contacted the operator of the residence and managed to convince the operator to withdraw the notice of increase.

While in Sarah's case her contact with the OALR and the referral to the Residential Tenancy Branch (RTB) resulted in a fair resolution, it is unreasonable to rely upon a process that requires people to contact an organization that explicitly states that it does not deal with tenancy issues in order to resolve tenancy complaints. Relying upon the RTB, an organization that has no mandate and no dedicated resources to deal with tenancy complaints made by assisted living residents, is equally problematic. This is not a reliable or transparent process, and does not ensure assisted living residents the right to have their tenancy-related complaints heard and addressed in a prescribed manner.

²⁸⁴ Ministry of Health, "Office of the Assisted Living Registrar — Complaint Investigation" <<http://www.health.gov.bc.ca/assisted/complaints.html>>.

²⁸⁵ The RTB also has responsibilities related to the *Manufactured Home Park Tenancy Act*.

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Attempts to Address the Protection Gap

The provincial government has been considering addressing the gaps in tenancy protection for people in supportive living facilities, and more recently assisted living residences, for more than a decade.²⁸⁶ At the request of a number of municipalities, the government formed the Inter-Ministerial Supportive Housing Review Committee in 1997. In 1999, the committee published a report that identified the need for consumer protection in what were then called “supportive living” facilities. In order to support the self-sufficiency of residents, the committee recommended this protection be similar to that provided by tenancy laws.

The provincial government passed the *Community Care and Assisted Living Act* in 2002. Although this presented an opportunity to address the gap in tenancy protection for assisted living residents, the committee’s recommendation was not implemented at that time.

In January 2003, the Inter-Ministerial Supportive Housing Review Committee held stakeholder consultations in six different locations to collect input from seniors, facility operators, government agencies and other interested organizations. In 2004, when the RTB took over leadership of the committee, it began facilitating informal resolutions

Forms of Protection Provided by the Tenancy Statutes Amendment Act

If the amendments proposed under the Tenancy Statutes Amendment Act (TSAA) were brought into force, assisted living and supportive housing residents would have the following forms of protection under the Residential Tenancy Act (RTA):

Rent Increases (RTA s. 41-43)

A landlord cannot increase rent more than once within a 12-month period without approval from the director, and may only increase rent by an amount prescribed by regulation. The amount prescribed by regulation is two per cent, plus the inflation rate.

Terminating or Restricting Services (RTA, s. 27(1); TSAA, s. 57.21 and 57.3)

A landlord cannot restrict or terminate hospitality services or personal care services that are essential to a resident’s use of the unit as a living accommodation or that form a material term of the tenancy agreement. Where this is not the case, a landlord must provide proper notice of the restriction or termination of a service, and a reduction in the amount payable under the service agreement for the service (as applicable).

Dispute Resolution (RTA, Part 5 — Resolving Disputes; TSAA, s. 57.51)

If a dispute arises between a landlord and tenant of an assisted or supportive living unit, whether or not an application for dispute resolution has been filed with the Residential Tenancy Branch, the tenant or landlord may request the director’s assistance in resolving the dispute informally. If a tenant or landlord applies for dispute resolution proceedings, the service agreement will be treated in the same way as a tenancy agreement.

²⁸⁶ In this section, “supportive living” refers to subsidized and non-subsidized living arrangements that provide a range of hospitality services, and may also offer additional features to enhance accessibility and safety. Supportive housing programs are outlined in more detail in the Background section of this report.

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of assisted living tenancy complaints referred to it by the Office of the Assisted Living Registrar (OALR). It intended this as a short-term solution to the lack of a dispute resolution mechanism for these types of complaints.

In 2005, the Inter-Ministerial Supportive Housing Review Committee recommended that the *Residential Tenancy Act (RTA)* be amended to cover assisted living residents. It also recommended that the RTB's dispute resolution processes be adapted for use by seniors in assisted living.

As a result, on April 26, 2006, the Minister of Health, on behalf of the Minister Responsible for Housing, introduced Bill 27, which contained amendments to the *Residential Tenancy Act* saying:

These amendments will mean that residents in assisted-living and supportive housing facilities will be protected by existing tenancy legislation. Until now, landlords and tenants of these facilities had to deal with disputes themselves or resort to the courts. Costly and complex court procedures meant that complaints often went unheard and unresolved. This bill will ensure that there is a simple and inexpensive way to resolve their disputes using the existing mechanisms in the Residential Tenancy and Manufactured Home Park acts.²⁸⁷

On May 10, 2006, the Minister Responsible for Housing in moving the second reading of Bill 27 said:

Until now, many residents of assisted living and supported housing facilities have had no way of dealing with landlord-tenant disputes other than going to court. Disputes were dropped, and concerns were not heard, all because this process can be complex and costly.

Amendments to the Act address that problem by extending protection under the *Residential Tenancy Act* to include this vulnerable group of people. ...

This bill will ensure that the voices of our seniors and of people living with disabilities will be heard in the residential tenancy office.²⁸⁸

On May 18, 2006, the Legislature passed the *Tenancy Statutes Amendment Act (TSAA)*, which was based on Bill 27. Although the *Tenancy Statutes Amendment Act (2006)* contained provisions addressing assisted living residences, they were never proclaimed, and so are still not in force. At the time of writing, no date has been set for proclamation.

Currently, the only option for addressing tenancy disputes in assisted living is the short-term, informal, unadvertised approach the RTB put in place in 2004.

The process set out in the *Tenancy Statutes Amendment Act* would result in a number of benefits for assisted living residents. In addition to the protection provided by the standard provisions for security deposits, repairs, rent increases, ending tenancies and dispute resolution under the *Residential Tenancy Act*, the

There is currently no timetable for the proclamation of the assisted living provisions in the Tenancy Statutes Amendment Act.

²⁸⁷ Minister of Health, British Columbia Legislative Assembly, Hansard, 26 April 2006, 1415 <<http://www.leg.bc.ca/hansard/38th2nd/H60426p.htm>>.

²⁸⁸ Minister Responsible for Housing, British Columbia Legislative Assembly, Hansard, 10 May 2006, 4665. <<http://www.leg.bc.ca/hansard/38th2nd/H60510p.htm>>.

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amendments proposed in the *TSAA* include additional protections for assisted living and supportive living tenants. For example, if the *TSAA* were brought into force, operators and residents would have to sign a service agreement in addition to a regular tenancy agreement.²⁸⁹ The service agreement would set out the hospitality and personal care services to be provided, the cost of these services and the landlord's right to access the rental suite in order to provide these services. As landlords, assisted living operators would have to separately list and charge their fees for shelter, hospitality services and personal care services, rather than lumping them together, as is the current practice. This would provide clearer information for assisted living residents and promote transparency and accountability among operators. This degree of transparency would ensure that rent increases comply with the provisions of the *RTA*.

After the *Tenancy Statutes Amendment Act* was passed, the government organized consultations with various groups in the fall of 2006. Some concerns that were raised involved the separation of fees and agreements for accommodation from those for services, which was not standard industry practice, as well as defining the appropriate lengths for notice periods.

In 2007, the government re-examined the provisions in the *Tenancy Statutes Amendment Act*, and in early 2008 it apparently decided not to implement them.

The Ministry Responsible for Housing then began exploring other methods for dealing with the gap in protection for assisted living residents. For example, it recognized the efforts operators were making to standardize assisted living rental agreements.

The Residential Tenancy Branch also met with stakeholders to explore what could be done to address the gap in the absence of legislation. According to the RTB, two main ideas were developed through this process. The first was to build on the work of operators and to develop a standardized tenancy agreement. The second was a dispute resolution pilot project that involved representatives of assisted living operators and residents forming a panel to deal with any disputes that could not be resolved in other ways. The RTB offered to coach panel members regarding its dispute resolution methods. The RTB has not yet adopted either of these interim measures.

Analysis

There is currently no formal process for dealing with complaints about tenancy issues in assisted living. Assisted living residents are not covered by the *Residential Tenancy Act* and fall outside the mandate of the Residential Tenancy Branch. The Residential Tenancy Branch does have an informal process to resolve tenancy issues for assisted living residents; however, this does not provide adequate legal protection for assisted living residents faced with tenancy problems. Due to their increased vulnerability, assisted living residents should reasonably receive equal or greater legal protection than other tenants.

The provincial government has been in the process of addressing the absence of tenancy protection for supportive living residents since 1997 and for assisted living residents since 2002. The *Tenancy Statutes Amendment Act* was enacted in May 2006. It has not yet been brought into force and the provincial government has no timetable for doing so. Instead, it is considering establishing an informal dispute

²⁸⁹ Supportive living in the Act refers to living arrangements in which hospitality or personal care services are provided. While supportive living tenants are included in the *Tenancy Statutes Amendment Act*, we do not include them throughout the discussion in this section because they are outside the scope of our investigation. Our focus here is on assisted living.

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resolution process in which complaints would be considered by a panel made up of landlord and tenant representatives. This process falls short of providing meaningful legal protection and will not fill the gap created by the exclusion of assisted living residents from the *Residential Tenant Act*.

It is unfair that assisted living residents, who are typically seniors and people with disabilities and thus face greater challenges than the average tenant, have a lower level of legal protection than is provided to other tenants. The government has delayed taking effective steps to provide assisted living residents with a level of legal protection that is equal to or greater than the protection available to other tenants. For ease of access, simplicity and clarity, the government should consider providing the Office of the Assisted Living Registrar with jurisdiction to handle complaints and disputes about tenancy issues in assisted living residences.

The Ombudsperson finds that

- F64. The Ministry Responsible for Housing, currently part of the Ministry of Energy and Mines, has not ensured that assisted living residents benefit from equal or greater legal protection afforded other, less vulnerable, tenants.

The Ombudsperson recommends that

- R82. The Ministry Responsible for Housing take the steps necessary to better protect assisted living residents by bringing the unproclaimed sections of the *Residential Tenancy Act* into force by January 1, 2013, or by developing another legally binding process to provide equal or greater protection by the same date.
- R83. The Ministry of Health, in consultation with the Ministry Responsible for Housing, consider whether to expand the jurisdiction of the Office of the Assisted Living Registrar to deal with complaints and disputes about tenancy issues in assisted living.
- R84. If the Ministry of Health decides not to include complaints about tenancy within the jurisdiction of the Office of the Assisted Living Registrar, the ministry require the Office of the Assisted Living Registrar to automatically refer tenancy issues to the agency that has the power to resolve them.

Monitoring

There are a variety of ways to monitor operators' compliance with standards and the quality of care provided in assisted living residences. These include inspections, complaint investigations and responding to reportable incidents. This section discusses how monitoring of assisted living is carried out by the Ministry of Health's Office of the Assisted Living Registrar.

Assisted living operators and residences are subject to the *Community Care and Assisted Living Act (CCALA)* and the *Assisted Living Regulation*. Oversight is carried out mainly in response to complaints, rather than on an ongoing and routine basis. Unlike residential care facilities licensed under the *CCALA*, assisted living residences are not subject to regular inspections by a licensing body.

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Role of the Office of the Assisted Living Registrar

The Office of the Assisted Living Registrar (OALR) is responsible by law for overseeing the health and safety of assisted living residents. One of the ways it carries out this responsibility is by reviewing and responding to applications to register assisted living residences. Operators are required under the *Community Care and Assisted Living Act* to register each of their residences. When an application for registration is received, OALR staff evaluate whether the residence meets the office's policy requirements. The OALR expects operators to notify it of any changes to registration information as they occur. The OALR can also evaluate a residence's compliance with ministry policies at any time if it believes that the health and safety of a resident is at risk.

Serious Incident Reporting

There are several distinctions between the requirements for incident reporting in assisted living facilities and for residential care facilities governed by the *Community Care and Assisted Living Act (CCALA)*. Significantly, residential care operators are legally required by the *CCALA* to immediately report reportable incidents, whereas operators of assisted living facilities are expected by the ministry's non-binding policy to maintain a record of serious incidents and report them to the OALR by the end of the next business day after they occur.²⁹⁰

There is also a distinction in terminology between assisted living and residential care. The *CCALA* refers to "reportable incidents," while the OALR uses the term "serious incident reporting." Additionally, while the *CCALA* sets out a long list of "reportable incidents" that residential care operators are required to report, the range of incidents that operators of assisted living residences are expected to report is much narrower. The ministry's policy defines serious incidents as outlined in the table below.

Table 21 – Types of Serious Incidents Reported to the Office of the Assisted Living Registrar, 2004 to 2010

	Abuse or neglect	Attempted suicide	Disease outbreak	Fire	Medication error	Unexpected death	Other	All serious incidents
2004/05	0	0	2	0	1	0	0	3
2005/06	1	1	6	0	1	7	1	17
2006/07	1	1	25	1	1	11	6	46
2007/08	0	5	10	2	1	17	13	48
2008/09	6	7	9	3	3	23	25	76
2009/10	5	5	3	5	7	33	19	77
2010/11	2	9	0	2	0	35	16	64
Total	15	28	55	13	14	126	80	331

The way that the ministry defines these incidents is also quite restrictive. For example, policy states that operators are to report medication errors only if residents require emergency care by a physician or transfer to a hospital. Under this definition, it is possible for serious, medication mistakes to go unreported to the OALR. The ministry only expects instances of abuse or neglect to be reported if they have first been reported

²⁹⁰ Office of the Assisted Living Registrar, *Registrant Handbook*, October 2009, Serious Incident Reporting, 8.1.

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to a health authority or to the public guardian and trustee. This again limits the number of reports made to the OALR. Another example is unexpected deaths, which the policy only wants operators to report if they are reported to the coroner.

The range of people to whom a report is made is also much wider in residential care than for assisted living. The *CCALA* requires residential care operators to report reportable incidents to the representative of the person in care, the person's doctor, the regional medical health officer and the funding program. In contrast, under ministry policy, assisted living facilities are expected to report serious incidents only to the OALR.

According to ministry policy, the general purpose of recording and tracking serious incidents is to reduce risks and improve the quality of services. Reporting serious incidents to the OALR allows the registrar to assess risk and consider whether further follow-up actions are warranted. Serious incident reporting also provides the OALR with information about risk patterns and trends.

However, as the following table shows, the number of serious incidents that have been reported to the OALR since 2004/05 is relatively low, especially given the number of assisted living residences and units. Although there were 194 assisted living residences in 2010/11 or 6,832 registered units, operators reported only 63 serious incidents to the OALR in the entire fiscal year.

Table 22 – Number of Serious Incidents Reported to the Office of the Assisted Living Registrar, 2004/05 to 2010/11

Fiscal year	Registered assisted living residences	Registered assisted living units	Serious incidents reported
2004/05	54	1,786	3
2005/06	96	3,367	17
2006/07	117	4,231	46
2007/08	150	5,235	48
2008/09	184	6,187	76
2009/10	196	6,685	77
2010/11	194	6,832	64

We asked the OALR how it ensures that operators comply with the requirement to submit serious incident reports. The OALR told us that it monitors whether operators have been filing serious incident reports when reviewing a file. In the summer of 2010, the OALR was planning to contact any residences that had not submitted a serious incident report in the last year to ensure that their operators were aware of and understood the reporting requirements. In response to our inquiries, the OALR reviewed its serious incident report records in early 2011 and determined that the OALR had never received a serious incident report from 77 registered residences (40 per cent of all residences) since 2004, when registration began.²⁹¹ As a result, in April 2011, the OALR emailed these operators to remind them of the reporting requirement. Unfortunately, however, operators are not required by regulation to report this information to the OALR and the OALR does not have authority to take enforcement action where operators do not comply.

²⁹¹ Of the 77 residences that had not submitted a serious incident report in 2009/10, 21 were registered in 2009/10.

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Finally, the information provided to us by the OALR suggests that its response to serious incidents that are reported has been very limited. The OALR told us that its staff review serious incident reports on the day they are received to assess the risks they pose to the health and safety of residents and to consider whether further actions, such as an inspection, are warranted. The OALR tracks the responses to serious incident reports on the files of individual residences and not in one central location, and staff were therefore unable to tell us conclusively how many times a serious incident report lead to an investigation or inspection. OALR staff estimated that since 2004 only four serious incident reports have led to formal investigations.

The Ombudsperson finds that

F65. Assisted living operators are not legally required to report serious incidents.

The Ombudsperson recommends that

R85. The Ministry of Health take the necessary steps to legally require assisted living operators to report serious incidents to the Office of the Assisted Living Registrar, the representative of the person in care, the person's doctor and the funding program.

The Ombudsperson finds that

F66. The list of serious incidents developed by the Ministry of Health for assisted living residences is less comprehensive than the list of reportable incidents for residential care facilities under the *Community Care and Assisted Living Act*.

The Ombudsperson recommends that

R86. The Ministry of Health review the current list of serious incidents applicable to assisted living residences and expand it.

The Ombudsperson finds that

F67. The Ministry of Health does not have a formal process to monitor operators' compliance with serious incident reporting.

The Ombudsperson recommends that

R87. The Ministry of Health develop a formal process to monitor operators' compliance with serious incident reporting requirements and ensure appropriate enforcement action is taken.

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Investigations and Inspections

The assisted living registrar does not routinely inspect assisted living residences. Rather, inspections may be done before registration or as part of a complaint investigation. Under the *Community Care and Assisted Living Act (CCALA)*, the registrar has the statutory authority to inspect assisted living residences when concerned about the health or safety of a resident or residents. This means that the registrar does not have authority to enter and inspect on a routine basis. This authority includes the power to enter and inspect a residence and make a copy of any record at the premises. The registrar does not have any authority to obtain information directly from employees or residents or to obtain records from contractors that are not at the premises. By contrast, medical health officers and their delegates who inspect and conduct investigations in residential care facilities have much more power under the same legislation. The *CCALA* gives medical health officers authority to examine any part of a facility, to require an operator to produce for inspection or copy the financial and other records of the facility, and to inquire into and inspect all matters concerning the facility, including its operations, employees and persons in care. This includes the authority to obtain information directly from staff and residents. The role of the Office of the Assisted Living Registrar (OALR) would be enhanced by giving the registrar additional investigative powers.

Assisted living residences are not subject to regular inspections or oversight by a licensing body.

As of March 31, 2011, the OALR has conducted a total of 40 inspections of 34 sites, meaning that the office has inspected only 18 per cent of all assisted living residences since 2004. Of those inspections, 21 were done prior to registration, 15 inspections were conducted in response to complaints, and 4 were follow ups to serious incident reports received by the OALR.

Although OALR staff are not required to announce an inspection beforehand, they notify operators in order to schedule a mutually convenient time.²⁹² The OALR has never conducted an unannounced inspection.

Ombudsperson staff reviewed five of the OALR's inspection files (13 per cent), selected on a random basis. We observed the following:

- inspections were thorough and appropriately assessed operators' compliance with OALR health and safety policies
- OALR staff completed inspection reports and noted the actions operators took to remedy instances of non-compliance
- once an operator addressed a deficiency, OALR staff sometimes updated (i.e., overwrote) the file without ensuring that the original record of non-compliance was preserved in their inspection report²⁹³
- the OALR does not assign risk ratings to facilities during inspections as is the practice of the health authorities that inspect residential care facilities licensed under the *CCALA*
- the OALR does not publicly report its inspection results. This practice also differs from what the health authorities do after inspecting residential care facilities licensed under the *CCALA*
- the OALR does not currently conduct random or unannounced inspections

²⁹² Ministry of Health, "Office of the Assisted Living Registrar — Frequently Asked Questions" <http://www.health.gov.bc.ca/assisted/faq.html#e_e>.

²⁹³ Once we brought this to the attention of OALR staff, they agreed to rectify this practice immediately.

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Analysis

Before the province implemented the Residential Care Access Policy in 2002, seniors who were assessed as needing assistance to manage their daily activities were generally categorized as in need of what was then called “intermediate care.” Seniors requiring this category of care often lived in a residential care facility licensed to provide such care. These facilities were monitored by each health authority’s licensing officers. This category of care no longer exists and seniors requiring such care are now most often placed in assisted living residences, where there is less regulatory protection and oversight. There is a significant disparity between the level of oversight that applies to residential care facilities licensed under the *Community Care and Assisted Living Act (CCALA)* and the oversight that applies to assisted living residences.

The oversight system for assisted living in British Columbia is based on the receipt of complaints and serious incident reports. To be effective, this system requires residents to feel comfortable putting forward complaints, and operators to use thorough incident reporting practices. We have found, however, that many residents are reluctant to complain. This is reflected in the fact that friends and family members of residents are the ones who make the majority of complaints about assisted living to both the Office of the Assisted Living Registrar (OALR) and our office. We have also found that the OALR has received a very small number of serious incident reports, which in light of the OALR’s limited power and inspection processes raises concerns. The criteria for reporting are too narrow; some operators may not be reporting; some may be unaware of the OALR policy requirement to report serious incidents. In the absence of more active inspections it is not possible to know.

Relying on responses to complaints and voluntary incident reporting to provide oversight of assisted living does not account for the realities and vulnerabilities of assisted living residents and is consequently an inadequate approach. Although seniors in assisted living are generally more capable and independent than those in residential care, they live in assisted living residences because they can no longer live safely on their own and need support. While it is positive that the regulatory framework for assisted living seeks to avoid intruding on residents’ lives, it is possible to respect their dignity and decisions, while still providing them with a higher level of oversight and regulatory protection.

According to the Ministry of Health, unannounced inspections are the best method of assessing a facility when it is in its usual routine, and announced inspections may be more appropriate where inspectors will need to spend time with a manager and need to ensure he or she is there during the inspection. Also according to the Ministry of Health, unannounced inspections are standard practice in most regulatory activities, such as restaurant and food inspections, liquor licensing, bylaw enforcement and occupational safety. By conducting few inspections in response to complaints and no random or unannounced inspections, the OALR is currently missing important monitoring opportunities and lacks the information it needs to be satisfied that the health and safety of residents is being maintained.

For the OALR to provide effective and appropriate oversight, it needs to expand its monitoring program. In order to achieve this, the Ministry of Health needs to develop processes for more routine and random monitoring of assisted living residences, require operators to report serious incidents and expand the legislative authority of the OALR to enable it to properly investigate and resolve complaints. OALR inspection reports should also be made public to enhance transparency.

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The Ombudsperson finds that

- F68. It is ineffective and inadequate for the Ministry of Health to rely on responding to complaints and serious incident reports as its main form of oversight for assisted living residences.

The Ombudsperson recommends that

- R88. The Ministry of Health develop an active inspection and monitoring program for assisted living including:
- a regular program for inspecting existing facilities
 - more frequent announced and unannounced inspections of facilities it receives complaints about
 - a risk-rating system for assisted living residences
 - publicly available inspection reports

The Ombudsperson finds that

- F69. Currently less than 11 per cent of assisted living residences were inspected by the Office of the Assisted Living Registrar to ensure they meet the requirements of the *Community Care and Assisted Living Act* for registration before they were registered.

The Ombudsperson recommends that

- R89. The Office of the Assisted Living Registrar develop and implement a program to conduct inspections of assisted living residences before they are registered.

The Ombudsperson finds that

- F70. The assisted living registrar has insufficient authority to obtain information needed to conduct effective investigations.

The Ombudsperson recommends that

- R90. The Ministry of Health take the necessary steps to expand the authority of the assisted living registrar to obtain information from all relevant parties, including employees, operators of assisted living residences, residents, contractors and others with information about incidents under investigation.

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Performance Management

The Ministry of Health also oversees assisted living by developing policy to ensure quality in the delivery of subsidized assisted living services. The ministry's revised *Home and Community Care Policy Manual*, which took effect April 1, 2011, includes a new chapter on performance management. This policy requires the ministry to develop provincial performance standards in collaboration with the health authorities. Health authorities in turn are required "to use performance data to measure and monitor improvement in quality of care and health outcomes for home and community care clients" and to submit data to the ministry in accordance with various established reporting requirements.²⁹⁴ It is important to note that this policy merely sets out a performance management process for contracted assisted living services; it is not a prescription for monitoring assisted living and is not a substitute for the monitoring activities of the Office of the Assisted Living Registrar.

The Ministry of Health has also recently developed a process to collect performance data on various performance measures. It told us that the provincial Home and Community Care Council has approved a Performance Management Framework for Assisted Living Residences that has three purposes:

- supporting the provision of quality services and care to assisted living residents
- improving the health outcomes of assisted living residents
- supporting a consistent approach to performance management in assisted living residences across the province²⁹⁵

The framework sets out a contract management process that applies to subsidized assisted living beds only. It includes performance measures in five areas: direct hours of care, number of falls, length of stay, medication errors and client satisfaction. Assisted living operators are supposed to submit data on each of these performance measures to their health authority. Each health authority will then develop and distribute quarterly reports to the assisted living operators in their region and to the Ministry of Health.

Although the health authorities do not have a role in monitoring assisted living services in the same way that they do with licensed residential care facilities, some have developed various processes for contract management in addition to the ministry's Performance Management Framework for Assisted Living Residences.

We asked each health authority about its role in evaluating the quality of services in assisted living residences that receive public funding. Northern Health told us that they were in the process of implementing the processes in the ministry's framework. Fraser Health has implemented the framework processes and set specific targets and reporting timelines for each of its five performance measures. Vancouver Coastal Health has developed additional performance measures, including cost-effectiveness and satisfaction levels of residents, families and community stakeholders. Vancouver Coastal Health sets out specific targets, the measurement tool to be used, the party responsible and the frequency of reporting required for each performance measure. VIHA implemented the framework process in April, 2009 and conducts site reviews and surveys residents annually.

²⁹⁴ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Performance Management: Information Requirements, 3.A.

²⁹⁵ Ministry of Health Services, *Provincial Performance Management for Assisted Living Residences*, April 2009, 2.

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Interior Health has developed a quality review tool that provides for the evaluation of facility policies, emergency response procedures, medication procedures, complaints processes, staffing, direct care hours, tenant satisfaction, food and nutrition, and recreational opportunities. Assisted living residences funded by Interior Health are supposed to be reviewed according to the following schedule:

- prior to opening a new or expanded residence
- six months after opening a new or expanded residence
- at least annually for all residences, and/or when reviews or complaints have raised quality concerns

It is the responsibility of the Home and Community Care director for the health service delivery area in which a facility is located, in collaboration with the local health service administrator, to ensure that these reviews are conducted. The Interior Health's review tool lists specific documentation that an operator is to provide as part of the review, but there is nothing to indicate that health authority staff will visit a site during the review process.

The implementation of the ministry's Performance Management Framework supports contract management and may provide the ministry with useful information about quality of care issues. It is thus a good step forward in information gathering. If all the health authorities would adopt the same tools and performance measures, the ministry could then use the resulting data to enhance its stewardship of the assisted living program.

The Ombudsperson finds that

- F71. The performance management approaches and practices, including the implementation of processes in the Ministry of Health's Performance Management Framework for Assisted Living, differ among the health authorities.

The Ombudsperson recommends that

- R91. The Ministry of Health work with the health authorities to standardize performance management processes for assisted living, and adopt the best practices within each health authority provincially.
- R92. The Ministry of Health make information it obtains under the Performance Management Framework for Assisted Living publicly available on an annual basis.

Enforcement

The *Community Care and Assisted Living Act* provides the Office of the Assisted Living Registrar (OALR) with limited enforcement powers. Section 27 of the Act allows the assisted living registrar to suspend, cancel, attach conditions to or vary the conditions of a residence's registration if operators are not complying with the Act, its regulations or the conditions of their registration.

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The Act allows the OALR to attach conditions to a registration only when the registrar has discovered non-compliance in the course of an inspection or complaint investigation. The registrar cannot attach conditions to a registration at the time a facility is first registered. If it could do so, the OALR would have a more effective enforcement tool, as it could make ongoing compliance with policies a condition of registration.

According to the registrar, the OALR follows an incremental, remedial approach to enforcement. The first step in this approach is to educate the complainant and the operator, where applicable. The OALR begins its discussion with operators by reviewing its own health and safety policies and the operator's policies and procedures. In cases where concerns about risks to the health and safety of residents have recurred, the OALR has stated that it takes a progressive enforcement approach — meaning that it applies more serious consequences in response to repeated infractions.²⁹⁶

However, as the following table indicates, the OALR has taken formal enforcement action under the Act only twice in seven years, once by cancelling an operator's registration, and once by attaching conditions to a registration.

Table 23 – Enforcement Actions Taken by the Office of the Assisted Living Registrar (OALR) 2004/05 to 2010/11

Fiscal year	Registered residences	Registered units	Times OALR attached conditions to a registration	Times OALR varied the conditions of a registration	Times OALR suspended a registration	Times OALR cancelled a registration
2004/05	54	1,786	0	0	0	0
2005/06	96	3,367	0	0	0	0
2006/07	117	4,231	0	0	0	0
2007/08	150	5,235	0	0	0	0
2008/09	184	6,187	0	0	0	1
2009/10	196	6,685	1	0	0	0
2010/11	194	6,832	0	0	0	0

Under section 33 of the *Community Care and Assisted Living Act*, the OALR also has the authority to recommend that Crown counsel charge anyone who operates an unregistered assisted living facility with an offence. The OALR told us that so far it has not recommended that Crown counsel do so.

²⁹⁶ Ministry of Health, "Office of the Assisted Living Registrar — Complaint Investigation" <<http://www.health.gov.bc.ca/assisted/complaints.html>>.

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Analysis

The relative lack of formal enforcement may be a result of operators complying with health and safety policies or of issues being addressed voluntarily. However, given the limited resources available to the Office of the Assisted Living Registrar (OALR) and the absence of a more rigorous monitoring program, no one can be confident this is the case.

The assisted living program has expanded rapidly since 2004/05. However, while the number of registered assisted living units tripled between 2004/05 and 2010/11, the OALR's funding decreased in the same period from \$571,454 to \$405,299.²⁹⁷ Considering the reduced resources of the OALR, the small number of inspections it has conducted, and the registrar's limited enforcement powers, it is not surprising that few enforcement actions have been taken. In addition to having a more rigorous monitoring program, we believe that the OALR needs a more active and progressive approach to enforcement.

The Ombudsperson finds that

F72. The Office of the Assisted Living Registrar is heavily dependent on an informal enforcement process and has only used its formal enforcement powers on two occasions in seven years.

The Ombudsperson recommends that

R93. The Ministry of Health review the Office of the Assisted Living Registrar's enforcement program to ensure that it has adequate resources and more power to actively ensure compliance with required standards.



²⁹⁷ The Ministry of Health informed us that the higher funding level in 2004/05 was partly due to 'start-up' costs for the Office of the Assisted Living Registrar.

Notes

Notes



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